

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25001

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William Joseph Blackert, Sr.,

2. Date of Death

August 2, 1997

3. Time of Death

11:45am

4a. Facility Name (If not institution, give street and number)

17706 Old Frederick Road

4b. City, Town, or Location of Death

Mt. Airy

4c. County of Death

Howard

Funeral
Director

5. Social Security Number

212-07-1578

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

80

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 3, 1917

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Mt. Airy

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

17706 Old Frederick Road

10f. Zip Code

21771

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Transportation

17. Father's Name (First, Middle, Last)

Joseph F. Blackert

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Laeffelholtz

19a. Informant's Name/Relationship (Type, Print)

Mrs. Angela M. Blackert (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17706 Old Frederick Road Mt. Airy, MD 21771

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☒ Other (Specify)

Entombment

20b. Place of Disposition (Name of cemetery, crematory or other place)

Crestlawn Mausoleum

Date

8/6/97

20c. Location - City or Town, State

Marriottsville, MD

21. Signature of Funeral Service Licensee

Brian A. Haight

22. Name and Address of Facility

HAIGHT FUNERAL HOME & CHAPEL (Box 195)
Sykesville, MD 21784 (410)-795-1400

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Small Cell Carcinoma of Right Lung

Approximate Interval Between Onset and Death

4 Months.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

N/A.

28b. Time of Injury

N/A.

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

N/A.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

N/A.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

N/A.

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mr. B. Blackert

29c. License number

D 30469.

29d. Date signed (Month, Day, Year)

August 3, 1997.

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

9055, Chevrolet Drive, #100, Ellicott City, MD 21042.

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

John P. Blackert

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25002

Certificate of Death

Reg. No.

| | | | | | |
|---|--|---|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) WILLIAM R. BAXTER | | 2. Date of Death Month 7 Day 26 Year 97 | | 3. Time of Death 0230 |
| | 4e. Facility Name (If not institution, give street and number) SHEPHERD TRAUMA CENTER, UNIV. OF MARYLAND | | 4b. City, Town, or Location of Death BALTIMORE, MD | | 4c. County of Death BALTIMORE |
| Funeral Director | 5. Social Security Number 220-01-3138 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 79 Yrs. | 8. Date of Birth (Month, Day, Year) January 19, 1918 | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | |
| To Be Completed by Funeral Director | 10a. State Delaware | 10b. County Kent | 10c. City, Town or Location Clayton | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10e. Street and Number 1896 Millington Road | | 10f. Zip Code 19938 | | 10g. Citizen of What Country? U.S.A. |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) | | |
| | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Assembly Man | | 16b. Kind of Business/Industry Metal Masters | | |
| | 17. Father's Name (First, Middle, Last) Edward Mason Baxter | | 18. Mother's Name (First, Middle, Maiden Surname) Effie Kemp | | |
| | 19e. Informant's Name/Relationship (Type, Print) James E. Baxter/Brother | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 133, Millington, Maryland 21651 | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Sudlersville Cemetery/July 30, 1997 | | 20c. Location - City or Town, State Sudlersville, Maryland |
| | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620 | | |
| | 23e. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Shock Due to (or as a consequence of): b. Sepsis Due to (or as a consequence of): c. Infarcted bowel Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Respiratory failure Chronic Lymphocytic leukemia Colonic pseudoobstruction | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier M. Gebremichael, MD | | 29c. License number D 42354 | |
| 29d. Date signed (Month, Day, Year) 07/26/97 | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) M. GEBREMICHAEL 22 S. Greene Street, Baltimore, Maryland | | | |
| 31. Date filed (Month, Day, Year) JUL 29 '97 | | 32. Registrar's Signature John Davidson-Randall | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

6

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25003

Certificate of Death

Reg. No.

| | | | | | | | | |
|-------------------------------------|--|--|---|--|--|--------------------------------|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Franklin Oliver Boulter | | | | 2. Date of Death Month July Day 29 Year 1997 | | 3. Time of Death 10:15 a.m. | |
| | 4a. Facility Name (If not institution, give street and number) 5585 Boundry Avenue (at home) | | | | 4b. City, Town, or Location of Death Rock Hall | | 4c. County of Death Kent | |
| Funeral Director | 5. Social Security Number 214-28-3663 | | 6. Sex MM <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 73 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) November 24, 1923 | |
| | Usual Residence of Decedent | | 9. Birthplace (State or Foreign Country) Maryland | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Kent | | 10c. City, Town or Location Rock Hall | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number 5585 Boundry Avenue | | | | 10f. Zip Code 21661 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) State Trooper | | 16b. Kind of Business/Industry State Police | | | |
| | 17. Father's Name (First, Middle, Last) John Edwin Boulter | | | | 18. Mother's Name (First, Middle, Maiden Surname) Sadie Grulkey | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Dorothy E. Boulter/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5585 Boundry Avenue, Rock Hall, Maryland 21620 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Wesley Cemetery/August 1, 1997 | | 20c. Location - City or Town, State Rock Hall, Maryland | | | |
| | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. e. STEM CELL LEUKEMIA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | |
| | 23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 YRS | | | | | | | |
| Physician /Medical Examiner | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| | 29b. Signature and title of certifier | | | | 29c. License number 1-13824 | | 29d. Date signed (Month, Day, Year) 7-29-97 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Seymour, MD., 122 Speer Road, Chestertown, Maryland 21620 | | | | | | | |
| | 31. Date filed (Month, Day, Year) JUL 30 '97 | | | | 32. Registrar's Signature | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

x

x

x

1 - WNW

~ Road, Ca

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25004

IRVIN L. BYRD

Items: 23a part I, 27, 28a-f per MEO G-750 8/26/97 dh

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|---|--|---|--------------------------------|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Irvin L. Byrd | | | | 2. Date of Death Month AUGUST Day 10 Year 1997 | | 3. Time of Death 5:30 AM | |
| | 4a. Facility Name (If not institution, give street and number) 3301 CHAUNCEY PLACE | | | | 4b. City, Town, or Location of Death MT. RAINER | | 4c. County of Death PRINCE GEORGES | |
| Funeral Director | 5. Social Security Number 577-90-8649 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 35 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 03-29-62 | 9. Birthplace (State or Foreign Country) Washington DC |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County Prince Georges | | 10c. City, Town or Location Mount Rainer | | 10d. Inside City Limits <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number 3301 Chauncey Place #202 | | | | 10f. Zip Code 20712 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 Collega (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housekeeping | | 16b. Kind of Business/Industry Domestic | | | |
| | 17. Father's Name (First, Middle, Last) Isaiah Byrd | | | | 18. Mother's Name (First, Middle, Maiden Surname) Christine Dickerson Byrd | | | |
| Physician /Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Christine Byrd | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1139 Zion Hill Road Keswick, VA 22947 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St. John Baptist Cem | | 20c. Location - City or Town, State 8/16/97 Cobham, VA | | 20d. Date | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility R.L. Gilliam Funeral Home, 203 8th Street NW Charlottesville, VA | | | |
| | 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. NARCOTIC, COCAINE AND ALCOHOL INTOXICATION Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) found: 8/10/97 | | 28b. Time of Injury found: 4:40 PM | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred unknown | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) found: residence | | | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3301 Chauncey Place, Mt. Rainer, MD. | | | | | | | |
| State Registrar | 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier  | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) AUGUST 10, 1997 | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MARGARET A. KORON 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 20 1997 | | | | 32. Registrar's Signature  | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

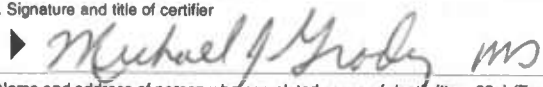
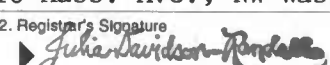
Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25005

Amend #17, 8/12/97, BMW, Montg. Co. per F.H. Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Thomas Stephen Cheston | | | | 2. Date of Death Month August 6, Day 1997 Year | | 3. Time of Death 2:45P.M. | |
| | 4a. Facility Name (If not institution, give street and number) Manor Care | | | | 4b. City, Town, or Location of Death Potomac | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 112-30-9710 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 56 Yrs. | | 8. Date of Birth (Month, Day, Year) July 2, 1941 | |
| | 9. Birthplace (State or Foreign Country) New York | | 10a. State Virginia | | 10b. County Fairfax | | 10c. City, Town or Location McLean | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 1431 Ironwood Drive | | 10f. Zip Code 22101 | |
| | 10g. Citizen of What Country? USA | | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) International Business Exc. | | 16b. Kind of Business/Industry Iridium LLC | |
| | 17. Father's Name (First, Middle, Last) Earl Chestnut Chesnutt | | | | 18. Mother's Name (First, Middle, Maiden Surname) Madeline Smith | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Arleen S. Cheston/wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1431 Ironwood Dr. McLean, VA 22101 | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory | | Date Aug. 7, '97 | | 20c. Location - City or Town, State Alex., VA | |
| | 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., N.W. Washington, D.C. 20007 | | | | | |
| | 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Malignant Melonoma Metastatic Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier  | | 29c. License number D38781 | | 29d. Date signed (Month, Day, Year) August 6, 1997 | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Grady, M.D. 4910 Mass. Ave., NW Wash., D.C. 20016 | | | | | | | |
| | 31. Date filed (Month, Day, Year) AUG 08 1997 | | 32. Registrar's Signature  | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item 23a or 23b-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25006

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|--|--|---|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) HAN JONG CHUN | | | | 2. Date of Death Month August Day 5 Year 1997 | | 3. Time of Death 11:35 AM | |
| | 4a. Facility Name (If not institution, give street and number) Magnolia Gardens Nursing Home | | | | 4b. City, Town, or Location of Death Lanham | | 4c. County of Death Prince Georges | |
| Funeral Director | 5. Social Security Number 220-08-7563 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 73 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) June 5, 1924 | 9. Birthplace (State or Foreign Country) Korea |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Prince Georges | | 10c. City, Town or Location College Park | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 4711 Berwyn House Road, #714 | | | | 10f. Zip Code 20740 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Asian | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Supervisor | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Supervisor | | | 16b. Kind of Business/Industry Retail Shopping Mall | |
| 17. Father's Name (First, Middle, Last) Byung Moon Chun | | | | 18. Mother's Name (First, Middle, Maiden Surname) Tae Sung Oh | | | | |
| 19a. Informant's Name/Relationship (Type, Print) In Hyung Chun / Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4711 Berwyn House Road, #714, College Park, MD 20740 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery | | Date 8/7/97 | | 20c. Location - City or Town, State Silver Spring, Maryland | | |
| 21. Signature of Funeral Service Licensee <i>June L. Holland</i> | | | | 22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic lung Cancer Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death one year |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier Sam T. Tellawi | | 29c. License number D34 274 | | 29d. Date signed (Month, Day, Year) 8.6.97 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAM TELLAWI, M.D. 7700 OLD BRANCH AVE. #B102 CLINTON, MD. 20735 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 08 1997 32. Registrar's Signature <i>John R. Rindall</i> | | | | | | | | |

Baltimore, Maryland 21215-0020

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1. The first part of the report is a general introduction to the subject.

2. The second part is a detailed description of the methods used.

3. The third part is a discussion of the results obtained.

4. The fourth part is a conclusion.

5. The fifth part is a list of references.

6.

7.

8. The sixth part is a summary of the work.

9. The seventh part is a list of the authors.

10. The eighth part is a list of the titles of the papers.

11. The ninth part is a list of the names of the institutions.

12. The tenth part is a list of the dates of the papers.

13. The eleventh part is a list of the places of the papers.

14. The twelfth part is a list of the subjects of the papers.

15. The thirteenth part is a list of the authors of the papers.

16. The fourteenth part is a list of the titles of the papers.

17. The fifteenth part is a list of the names of the institutions.

18. The sixteenth part is a list of the dates of the papers.

19. The seventeenth part is a list of the places of the papers.

20. The eighteenth part is a list of the subjects of the papers.

21. The nineteenth part is a list of the authors of the papers.

22. The twentieth part is a list of the titles of the papers.

23. The twenty-first part is a list of the names of the institutions.

24. The twenty-second part is a list of the dates of the papers.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25007

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Shirley MAE COADY

2. Date of Death

Month
AugDay
1Year
1997

3. Time of Death

8:09 PM

4a. Facility Name (If not institution, give street and number)

11700 Old Columbia Pike #517

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

229-26-8052

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

Dec. 16, 1929

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Saint Marys

10c. City, Town or Location

Mechanicsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3709 East Winston Drive

10f. Zip Code

20659

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Waitress

16b. Kind of Business/Industry

Food Service

17. Father's Name (First, Middle, Last)

Charles William Blue

18. Mother's Name (First, Middle, Maiden Surname)

Estelle Finnacon

19a. Informant's Name/Relationship (Type, Print)

James J. Coady

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3709 East Winston Drive Mechanicsville, Maryland 20659

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

8/6/97

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.
500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hypertensive heart Disease
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D08546

29d. Date signed (Month, Day, Year)

Aug 1 - 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John T. Taylor 8218 Wisconsin Ave Bethesda Md

31. Date filed (Month, Day, Year)

AUG 6 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner




Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25008

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|---|--|---|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MARY A. CROSS | | | | 2. Date of Death Month August Day 1 Year 1997 | | 3. Time of Death 0710 | | |
| | 4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER | | | | 4b. City, Town, or Location of Death SALISBURY | | 4c. County of Death WICOMICO | | |
| Funeral Director | 5. Social Security Number 420-07-8719 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 77 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) FEB. 24, 1920 | 9. Birthplace (State or Foreign Country) ALABAMA | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MARYLAND | | 10b. County WORCESTER | | 10c. City, Town or Location OCEAN CITY | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | 10e. Street and Number 100 PINE TREE ROAD | | | | 10f. Zip Code 21843 | | 10g. Citizen of What Country? USA | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) GRAPHIC ARTIST | | 16b. Kind of Business/Industry NASA | | | | |
| | 17. Father's Name (First, Middle, Last) JACKSON BROWNING | | | | 18. Mother's Name (First, Middle, Maiden Surname) ELSIE CROCKER | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) HOWARD F. CROSS/HUSBAND | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 1771, MBS, OCEAN CITY, MARYLAND 21843 | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) SUNSET MEMORIAL PARK | | Data 8/4/97 | | 20c. Location - City or Town, State BERLIN, MARYLAND | | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Metastatic Adenocarcinoma Lung | | | | | | | | |
| | 23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Lumbar Spine and cerebral metastasis | | | | | | | | |
| 23c. Part III. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Lumbar Spine and cerebral metastasis | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) 8/4/97 | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and Title of certifier  | | 29c. License number D 47619 | | 29d. Date signed (Month, Day, Year) 8/1/97 | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr. Charles W. Hastings 262 Trighman Rd. Salisbury MD 21804 | |
| 31. Date filed (Month, Day, Year) AUG 05 1997 | | 32. State Registrar  | | | | | | | |

Mary F. Cross SS# 420-07-8719

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25009

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|--|--|--|--|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) DALE W. CLIFTON, SR. | | | | 2. Date of Death Month: July Day: 30 Year: 1997 | | 3. Time of Death 1339 | | | |
| | 4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER | | | | 4b. City, Town, or Location of Death SALISBURY | | 4c. County of Death WICOMICO | | | |
| Funeral Director | 5. Social Security Number 221-18-2814 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 76 Yrs. | | 8. Date of Birth (Month, Day, Year) JAN. 24, 1921 | | | |
| | 9. Birthplace (State or Foreign Country) ANGOLA, DE | | 10a. State DELAWARE | | 10b. County SUSSEX | | 10c. City, Town or Location MILTON | | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 10e. Street and Number 740 MULBERRY ST., EXT. | | 10f. Zip Code 19968 | | | |
| | 10g. Citizen of What Country? USA | | | | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: | | | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 Collage (1-4or 5+) | | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BUILDING/GROUNDS SUPERVISOR | | | | 16b. Kind of Business/Industry SCHOOLS | | | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) JOHN E. CLIFTON | | | | 18. Mother's Name (First, Middle, Maiden Surname) JENNIE WELLS | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) RETTA CLIFTON | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 740 MULBERRY ST., EXT., MILTON, DE 19968 | | | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) ODD FELLOWS CEMETERY | | 20c. Location - City or Town, State MILTON, DELAWARE | | | |
| | 21. Signature of Funeral Service Licensee George M. Short | | | | 22. Name and Address of Facility SHORT FUNERAL SERVICES, INC. 416 FEDERAL ST., P.O. BOX 233, MILTON, DE 19968 | | | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Respiratory failure 2° to Due to (or as a consequence of): b. progressive/widespread Malignant Due to (or as a consequence of): c. Lymphoma Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier Joseph A. Grasso MD | | | | 29c. License number D 20507 | |
| | 29d. Date signed (Month, Day, Year) 7/31/97 | | | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Joseph A. Grasso 145 E. Carroll St Salisbury MD | | | | | |
| To Be Completed by Physician/Medical Examiner | 31. Date filed (Month, Day, Year) AUG 04 1997 | | | | 32. Registrar's Signature John A. Randall | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 25010**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Carrol W. Cordrey

2. Date of Death

Month

Day

Year

July

27 1997

3. Time of Death

1535

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral
Director

5. Social Security Number

221-18-2460

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Nov 3, 1924

9. Birthplace (State or Foreign Country)

Delaware

Usual Residence of Decedent

10e. State

DE

10b. County

Sussex

10c. City, Town or Location

Delmar

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

Rt# 1 Box 520

10f. Zip Code

19940

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
11

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Farmer

16b. Kind of Business/Industry

Grain

17. Father's Name (First, Middle, Last)

Lynn Cordrey

18. Mother's Name (First, Middle, Maiden Surname)

Lola Henry

19e. Informant's Name/Relationship (Type, Print)

Annabel Cordrey / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Rt# 1 Box 520 Delmar, DE 19940

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Odd Fellows Cemetery

Date

7-31-1997

20c. Location - City or Town, State

Laurel, Delaware

21. Signature of Funeral Service Licensee

Holly Short-Harrigan

22. Name and Address of Facility

Short Funeral Home, Inc.
700 West St. Laurel, DE 1995623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)e. Anorectic Latent Sclerosis
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Lastb. Respiration Failure
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24e. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Steven F. Hearne, MD

29c. License number

040715

29d. Date signed (Month, Day, Year)

7/28/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Steven F. Hearne, MD

403 Quincey St.

Salisbury, Md. 21804

31. Date filed (Month, Day, Year)

JUL 31 1997

32. Registrar's Signature

John Harrison

State
Registrar

Carrol W. Cordrey
221-18-2460
Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25011

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Carlos M. Dixon, Sr.

2. Date of Death

August 2, 1997

3. Time of Death

6:45 AM

4a. Facility Name (If not institution, give street and number)

Mariner Health - Kensington

4b. City, Town, or Location of Death

Kensington

4c. County of Death

Montgomery

5. Social Security Number

220-44-2036

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

96

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 1, 1901

9. Birthplace (State or Foreign Country)

Georgia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8505 Springvale Road

10f. Zip Code

20910

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Foreman

16b. Kind of Business/Industry

D.C. Government

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Unknown

19a. Informant's Name/Relationship (Type, Print)

Carlos M. Dixon, Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5684 Barberry Court Frederick, Maryland 21703

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

8/4/97

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Atherosclerotic Coronary Heart Disease

Approximate
Interval Between
Onset and Death

Years

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus; multi-infarct

Dementia; Senile Cachexia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D 08944

29d. Date signed (Month, Day, Year)

August 4, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Martin C. Shargel, M.D. 3720 Farragut Avenue Kensington, Maryland 20895-2110

31. Date filed (Month, Day, Year)

AUG 4 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25012

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Louise V. Donovan

2. Date of Death

August 4, 1997

3. Time of Death

9:50 PM

4a. Facility Name (If not institution, give street and number)

11206 River View Drive

4b. City, Town, or Location of Death

Potomac

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

012-20-9125

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 19, 1907

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Potomac

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11206 River View Drive

10f. Zip Code

20854

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

James Eagen

18. Mother's Name (First, Middle, Maiden Surname)

Anastasia Walsh

19a. Informant's Name/Relationship (Type, Print)

Anastasia Kelly/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11206 River View Drive, Potomac, MD 20854

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) Aug. 8, 1997

Veterans National Cemetery

20c. Location - City or Town, State

Bourne, Massachusetts

21. Signature of Funeral Service Licensee

Michael P. Kutta M00348

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Rockville, Inc., 300 W. Montgomery Avenue,
Rockville, Maryland 20850-2805

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Arrest

Immediate

Due to (or as a consequence of):

b. Coronary Artery Disease

10 years

Due to (or as a consequence of):

c. Congestive Heart Failure

5 years

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular Accident 1979

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Edward Gwozdz M.D.

29c. License number

DC3282

29d. Date signed (Month, Day, Year)

August 5, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. Edward Gwozdz, M.D., 600 New Hampshire Ave., NW, #359, Washington, DC 20037

31. Date filed (Month, Day, Year)

AUG 07 1997

32. Registrar's Signature

Gene Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25013

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|---|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Sabrina Diane Dunbar | | | | 2. Date of Death Month August Day 3 Year 1997 | | 3. Time of Death 8:25 AM | |
| | 4a. Facility Name (If not institution, give street and number) 8515 Greenbelt Road #101 | | | | 4b. City, Town, or Location of Death Greenbelt | | 4c. County of Death Prince George's | |
| Funeral Director | 5. Social Security Number 228-29-0657 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 31 Yrs. | | 8. Date of Birth (Month, Day, Year) December 10, 1965 | |
| | 9. Birthplace (State or Foreign Country) New York | | 10a. State Maryland | | 10b. County Prince George's | | 10c. City, Town or Location Greenbelt | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 8515 Greenbelt Road #101 | | 10f. Zip Code 20770 | | 10g. Citizen of What Country? United States | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Marketing | | 16b. Kind of Business/Industry Nextel Communications, Inc. | | | |
| | 17. Father's Name (First, Middle, Last) Stephen Dunbar | | | | 18. Mother's Name (First, Middle, Maiden Surname) Judy Rogan | | | |
| Physician /Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Judy Rogan Mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 120 Panorama Drive, Edgewater, New Jersey 07020 | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory | | 20c. Location - City or Town, State 8-4-97 Beltsville, Maryland | | 20d. Date | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, MD 20910 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Breast Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death 18 months | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier  | | | | 29c. License number D18912 | | 29d. Date signed (Month, Day, Year) August 4, 1997 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen Staal, M. D., 8300 Corporate Drive, Landover, MD 20785 | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) AUG 05 1997 | | | | 32. Registrar's Signature  | | | |
| | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25014

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Fannie E. Dickerson

2. Date of Death

August 5, 1997 0630

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

5. Social Security Number

222-56-3076

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 11, 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

DE

10b. County

Sussex

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

Rt. # 3 Box 335

10f. Zip Code

19956

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Marion Lee Ellis

18. Mother's Name (First, Middle, Maiden Surname)

Fannie May Phillips

19a. Informant's Name/Relationship (Type, Print)

Tammera J. Ward - daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Rt. 3 Box 318A Laurel, DE 19956

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fireman's Cemetery

Date

8-8-97

20c. Location - City or Town, State

Sharptown, MD

21. Signature of Funeral Service Licensee

Gerald C. Bounds

22. Name and Address of Facility

705 E. Main St.
Bounds Funeral Home Salisbury, MD 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. *Hepato-Renal Syndrome*
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *Advanced liver cirrhosis secondary to cholestasis*
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Rheumatic Heart Disease & chronic valvular dysfunction & mitral insufficiency & history of heart failure. In the distant past, coronary artery disease & congestive heart failure. M.H. history of mitral cell carcinoma of breast

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

James H. Clifford MD

29c. License number

001969

29d. Date signed (Month, Day, Year)

8/5/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

JAMES H. CLIFFORD MD 106 PINE BLUFF RD Sock 12 Salisbury, MD 21801

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

*Spina Harrison-Randall*State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Fannie E. Dickerson 55# 222-56-3076

Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25015

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Cloyd H. Eichelberger, Jr.

2. Date of Death

Month Day Year
Aug 3, 1997

3. Time of Death

10:40am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

218-38-7124

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

54

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 15, 1943

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4006 Havard Street

10f. Zip Code

20906

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Officer

16b. Kind of Business/Industry

Security

17. Father's Name (First, Middle, Last)

Cloyd H. Eichelberger

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Simmons

19a. Informant's Name/Relationship (Type, Print)

Ronalda Eichelberger

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4006 Havard Street Silver Spring, Maryland 20906

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Parklawn Memorial Park

Date

8/7/97

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

Tracy A. Stuever

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

MINUTES

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. SEIZURE WITH HYPOXEMIA

Due to (or as a consequence of):

MINUTES

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE
HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John J. Merendino Jr.

29c. License number

D36046

29d. Date signed (Month, Day, Year)

Aug 4, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4701 RANDOLPH RD #216

JOHN J. MERENDINO JR, M.D.
ROCKVILLE MD 20852

31. Date filed (Month, Day, Year)

AUG 07 1997

32. Registrar's Signature

John Davidson-Rendall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

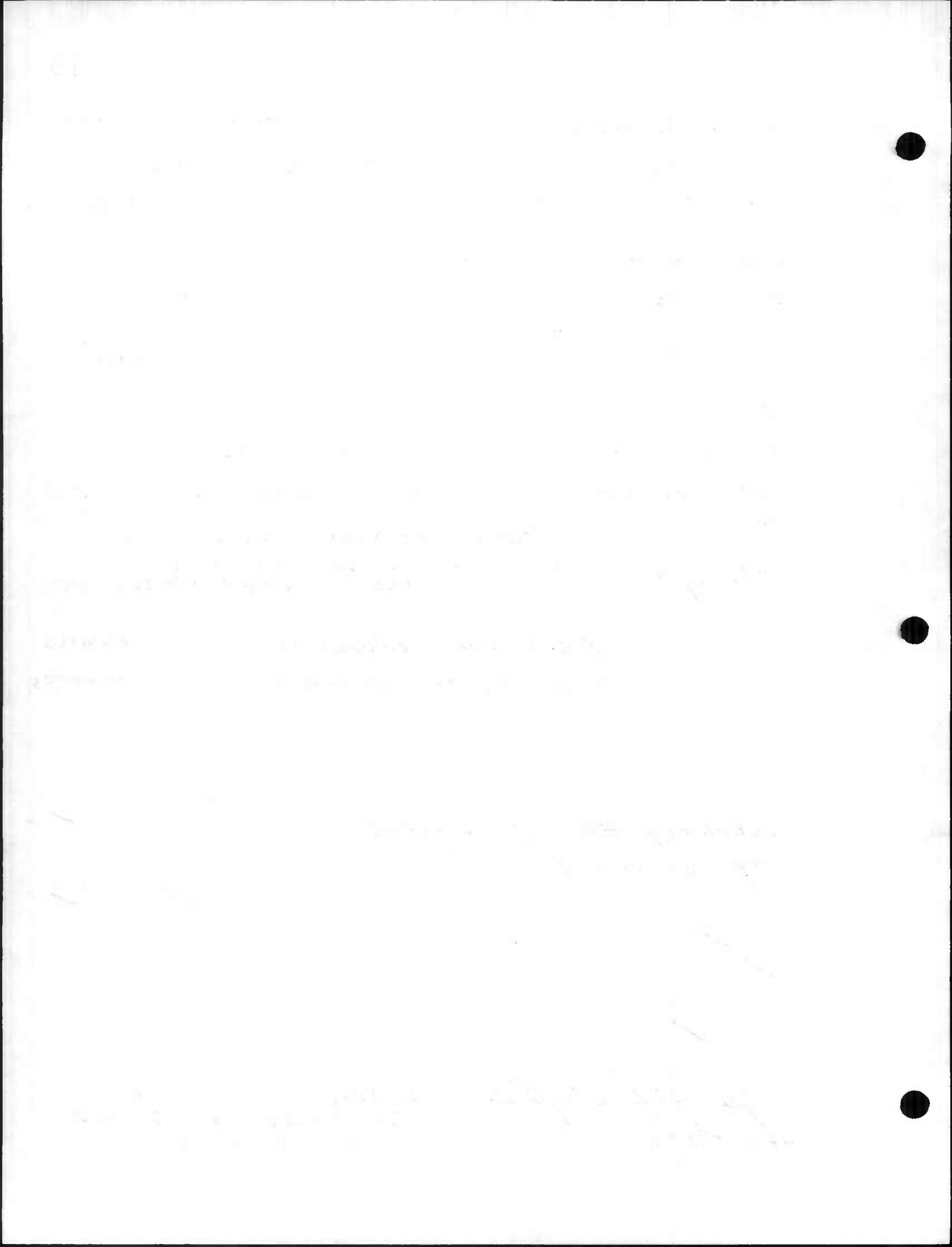
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25016

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Wendall Justin Evans

2. Date of Death

Month July 31, 1997 Year

3. Time of Death

9:30P.

4e. Facility Name (If not institution, give street and number)

Golden Oaks Nursing Home

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

577-03-7053

6. Sex

XXM 2□ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month, Day, Year
Aug. 17, 1913

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10e. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

XX Yes 2□ No

10e. Street and Number

3305 Gumwood Drive

10f. Zip Code

20783

10g. Citizen of What Country?

United States

11. Marital Status

1□ Never Married 2□ Married

3XX Widowed 4□ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1□ Yes 2XX No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1□ Yes 2XX No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Test Engineer

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Walter

Evans

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Grace Bean

19e. Informant's Name/Relationship (Type, Print)

Ilene Forsbacka (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4814 Naples Avenue Beltsville, Maryland 20705

20e. Method of Disposition

XX Burial 2□ Cremation 3□ Removal from State

4□ Donation 5□ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery 8/4/1997

Date

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

Donald V. Borgwardt

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, P.A.
4400 Powder Mill Rd. Beltsville, Maryland 20705

23e. Pert. I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. ASTROCYTOMA
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

MONTHS

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ORGANIC BRAIN SYNDROME

SEIZURES

23b. Did tobacco use contribute to the cause of death?

1□ Yes 2□ No 3□ Probably 4XX Unknown

24a. Was an autopsy performed?

1□ Yes 2XX No

24b. Were autopsy findings available prior to completion of cause of death?

1□ Yes 2XX No

25. Was case referred to medical examiner?

1□ Yes 2XX No

Hospital:

1□ Inpatient

2□ ER/Outpatient

3□ DOA

Other:

26. Place of Death (Check only one)

XX Nursing Home

5□ Residence

6□ Other (Specify)

27. Manner of Death

1XX Natural

2□ Accident

3□ Suicide

4□ Homicide

5□ Pending Investigation

6□ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1□ Yes 2XX No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of Certifier

Robert Y. Maggin, M.D.

29c. License number

D25422

29d. Date signed (Month, Day, Year)

August 1, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Y. Maggin, M.D. 14333 Laurel Bowie Rd., #307 Laurel, Maryland 20708-1160

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

97 25017

Reg. No.

DMMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 25018**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LUCY YATES FABER

2. Date of Death

Month Day Year
July 30, 1997

3. Time of Death

5:30 AM

4a. Facility Name (If not institution, give street and number)

Manor Care Health Services

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery County

Funeral
Director

5. Social Security Number

212-20-1044

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 1, 1912

9. Birthplace (State or Foreign Country)

Maine

Usual Residence of Decedent

10a. State

Virginia

10b. County

None

10c. City, Town or Location

Alexandria

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5009 Regency Place

10f. Zip Code

22304

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

if Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

Caucasian

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Nurse

16b. Kind of Business/Industry

Private Company

17. Father's Name (First, Middle, Last)

John H. Yates

18. Mother's Name (First, Middle, Maiden Surname)

Alethea Bleeker

19a. Informant's Name/Relationship (Type, Print)

Linda Pyle - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7404 Maple Avenue - Takoma Park, Maryland 20912

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

No. Va. Crematory

Date

8-1-97

20c. Location - City or Town, State

Arlington, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Arlington Funeral Home - Arlington, Va. 22203

3901 North Fairfax Drive

23a. Part I: Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Respiratory Failure

Due to (or as a consequence of):

Suddenly

b. Congestive Heart Failure

Due to (or as a consequence of):

Weeks

c. Chronic Renal Failure

Due to (or as a consequence of):

Months

d. Hypertension

Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D - 32332

29d. Date signed (Month, Day, Year)

July 30, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Suresh Kumar Gupta, MD - 9801 Georgia Avenue - Silver Spring, Maryland 20902-5288

31. Date filed (Month, Day, Year)

AUG 5 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25019

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

PHILIP V FLEMING

2. Date of Death

Month
August

Day

6

Year

1997

3. Time of Death

4:55 P.M.

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

010-09-1027

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Aug. 12, 1916

9. Birthplace (State or Foreign Country)

MA

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

9134 Kirkdale Road

10f. Zip Code

20817

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Director of Food & Nutrition Division

16b. Kind of Business/Industry

US Dept. of Agriculture

17. Father's Name (First, Middle, Last)

Sheridan Fleming

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Quinn

19a. Informant's Name/Relationship (Type, Print)

Sophie P. Fleming - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9134 Kirkdale Road Bethesda, MD 20817

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glenwood Cemetery

Date

8/9/97

20c. Location - City or Town, State

Washington, D. C.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Joseph Gawler's Sons
5130 WI Ave. NW Washington, D.C. 20016

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. PANCREATIC CARCINOMA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. EXTENSIVE METASTATIC DISEASE

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D-27660

29d. Date signed (Month, Day, Year)

8/6/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ALPANA GOSHWAMI M.D. 10901 CONNETT AVE, KENSINGTON, MD 20910

31. Date filed (Month, Day, Year)

AUG 08 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25020

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

KATHRYN W. FOSTER

2. Date of Death

Month

Day

Year

3. Time of Death

9:43 PM

4a. Facility Name (If not institution, give street and number)

LAUREL REGIONAL HOSPITAL

4b. City, Town, or Location of Death

LAUREL

4c. County of Death

PRINCE GEORGES

Funeral
Director

5. Social Security Number

147-24-7487

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

MAY 20, 1926

9. Birthplace (State or Foreign Country)

NEW JERSEY

Usual Residence of Decedent

10a. State

D.C.

10b. County

NONE

10c. City, Town or Location

WASHINGTON

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

815 48th ST. N.E.

10f. Zip Code

20019

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

AT HOME

17. Father's Name (First, Middle, Last)

FRANK

WEBSTER

18. Mother's Name (First, Middle, Maiden Surname)

DOROTHY

CARPENTER

19a. Informant's Name/Relationship (Type, Print)

MARQUITA FOSTER/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12301 TREE TOP DR. #33, SILVER SPRING, MD. 20904

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

CHAMBERS CREMATORY

Date

8/4/97

20c. Location - City or Town, State

RIVERDALE, MD.

21. Signature of Funeral Service Licensee

M. Chambers

M00091

22. Name and Address of Facility

CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a.

Bilateral pneumonia

Due to (or as a consequence of):

b.

Pleural effusion

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Liver cirrhosis

Esophageal varices

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier
(Check only
one)1 ☐ Certifying Physician:

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☒ Medical Examiner:

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

P. S. Autla M.D.

29c. License number

D42580

29d. Date signed (Month, Day, Year)

07-28-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

P.S. AUTLA MD. 5632 ANNAPOLIS RD #13 BLADENBURG MD 20710.

31. Date filed (Month, Day, Year)

AUG 4 1997

32. Registrar's Signature

Julia Davidson-Rendall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25021

Amend #17, 8/4/97, BMW, Montg. Co per F.H.

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CHARLOTTE M.

2. Date of Death

Month

Day

Year

July

30, 1997

3. Time of Death

7:00pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

5. Social Security Number

127-18-9632

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

March 8, 1926

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

11215 Oak Leaf Drive #1120

10f. Zip Code

20901

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

~~Casper Hill~~

Casper Hill Billip

18. Mother's Name (First, Middle, Maiden Surname)

Charlotte Hebbard

19a. Informant's Name/Relationship (Type, Print)

Susan M. Winters

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11010 Cone Lane Wheaton, Maryland 20902
Lewisburg Cemetery 8/03/97 Lewisburg, Pennsylvania

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lewisburg Cemetery

Date

8/03/97 Lewisburg, Pennsylvania

21. Signature of Funeral Service Licensee

Robert E. Ramsey

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.
500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Hypoxia

Approximate Interval Between Onset and Death

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

e. Due to (or as a consequence of)

pulmonary effusion/edema

b. Due to (or as a consequence of)

pulmonary embolism

c. Due to (or as a consequence of)

colon cancer (metastatic)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

partial gastrectomy
Filter placed
anemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title of certifier
29c. License number
29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

Rashed Byh Nam

29c. License number

D39372

29d. Date signed (Month, Day, Year)

July 30, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

KASHID BAGHAI - NAINI 344 UNIVERSITY BLVD
West Suit 324 Silver Spring, md 20901

31. Date filed (Month, Day, Year)

AUG 4 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25022

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|---|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>Sara Long Frey</u> | | | | 2. Date of Death Month <u>Aug</u> Day <u>4</u> Year <u>1997</u> | | 3. Time of Death <u>12:15 PM</u> | |
| | 4a. Facility Name (If not institution, give street and number) <u>Holy Cross Hospital</u> | | | | 4b. City, Town, or Location of Death <u>Silver Spring</u> | | 4c. County of Death <u>Montgomery</u> | |
| Funeral Director | 5. Social Security Number <u>175-03-3193</u> | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) <u>80</u> Yrs. | | 8. Date of Birth (Month, Day, Year) <u>Nov. 10, 1916</u> | |
| | 9. Birthplace (State or Foreign Country) <u>Pennsylvania</u> | | 10a. State <u>Maryland</u> | | 10b. County <u>Montgomery</u> | | 10c. City, Town or Location <u>Silver Spring</u> | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number <u>11610 Idlewood Road</u> | | 10f. Zip Code <u>20906</u> | | 10g. Citizen of What Country? <u>United States</u> | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <u>White</u> | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Manager</u> | | 16b. Kind of Business/Industry <u>Drapery Store</u> | | 17. Father's Name (First, Middle, Last) <u>Percy Long</u> | |
| | 18. Mother's Name (First, Middle, Maiden Surname) <u>Jessie Shoupe</u> | | 19a. Informant's Name/Relationship (Type, Print) <u>Virginia F. Gandy/Daughter</u> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>4503 Mahan Road, Silver Spring, Maryland 20906</u> | | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Montgomery Crematorium, Inc.</u> | | 20c. Location - City or Town, State <u>Bethesda, Maryland</u> | | 21. Signature of Funeral Service Licensee <u>David E. Perry</u> M00803 | | 22. Name and Address of Facility <u>Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805</u> | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>a. Respiratory Failure</u> Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <u>b. Due to (or as a consequence of):</u> <u>c. Due to (or as a consequence of):</u> <u>d. Due to (or as a consequence of):</u> | | Approximate Interval Between Onset and Death <u>1-2 weeks</u> | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | |
| | 28a. Date of Injury (Month, Day, Year) <u>August 4, 1997</u> | | 28b. Time of Injury <u>M</u> | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <u>At home</u> | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) <u>50 W Edmonston Drive Rockville MD 20852</u> | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and Title of certifier <u>William C. [Signature]</u> | |
| | 29c. License number <u>D29816</u> | | 29d. Date signed (Month, Day, Year) <u>August 4, 1997</u> | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Radhey Murarka</u> | | 31. Date filed (Month, Day, Year) <u>AUG 07 1997</u> | |
| To Be Completed by Physician/Medical Examiner | 32. Registrar's Signature <u>John Davidson-Randall</u> | | 33. Date of Death <u>August 4, 1997</u> | | 34. Time of Death <u>12:15 PM</u> | | 35. Place of Death <u>Silver Spring, Maryland</u> | |
| | 36. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Radhey Murarka</u> | | 37. Date of Death <u>August 4, 1997</u> | | 38. Time of Death <u>12:15 PM</u> | | 39. Place of Death <u>Silver Spring, Maryland</u> | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25023

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|---|--|---|---|--|---|
| 1. Decedent's Name (First, Middle, Last) <i>Simon</i> | | 2. Date of Death Month <i>August</i> Day <i>11</i> Year <i>1997</i> | | 3. Time of Death <i>12:30AM</i> | |
| 4a. Facility Name (If not institution, give street and number) <i>Washington Adventist Hospital</i> | | 4b. City, Town, or Location of Death <i>Takoma Park</i> | | 4c. County of Death <i>P.G. County</i> | |
| 5. Social Security Number <i>577-76-5761</i> | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) <i>60</i> Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) <i>July 6, 1937</i> |
| 9. Birthplace (State or Foreign Country) <i>Bolivia</i> | | | | | |
| Usual Residence of Decedent: | | | | | |
| 10a. State <i>DC</i> | 10b. County | 10c. City, Town or Location <i>Washington</i> | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10e. Street and Number <i>1833 New Hampshire Ave. NW</i> | | | 10f. Zip Code | | 10g. Citizen of What Country? <i>Bolivia</i> |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: <i>Hispanic</i> | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>9th</i> College (1-4 or 5+) | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Waiter</i> | | 16b. Kind of Business/Industry <i>Pidgwell's Carter</i> | | | |
| 17. Father's Name (First, Middle, Last) <i>(Unknown) Franco</i> | | | 18. Mother's Name (First, Middle, Maiden Surname) <i>Marcelina Franco</i> | | |
| 19a. Informant's Name/Relationship (Type, Print) <i>Anselma A. Franco/Wife</i> | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1833 New Hampshire Ave. NW Washington, DC 200</i> | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Nt. Olivet Cemetery</i> | | 20c. Location - City or Town, State <i>Washington, DC</i> | |
| 21. Signature of Funeral Service Licensee <i>W.H. Bacon</i> | | 22. Name and Address of Facility <i>W.H. Bacon Funeral Home 3447 14th St. NW Wash., DC 20010</i> | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | | | | |
| a. <i>Septic shock -</i> | | | | | |
| Due to (or as a consequence of): | | | | | |
| b. <i>Progressive Neurologic disorder</i> | | | | | |
| Due to (or as a consequence of): | | | | | |
| c. | | | | | |
| Due to (or as a consequence of): | | | | | |
| d. | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury <i>M</i> | |
| 28c. Injury et Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier <i>Julia Anderson-Randall</i> | | 29c. License number <i>D 48290</i> | | 29d. Date signed (Month, Day, Year) <i>AUGUST 11, 1997</i> | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>CARLOS E COVARRUBIAS M.D. 8121 GEORGIA AVE #405 S.S. MD 20910</i> | | | | | |
| 31. Date filed (Month, Day, Year) <i>AUG 20 1997</i> | | 32. Registrar's Signature <i>Julia Anderson-Randall</i> | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25024

Fitchett, Herman

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Herman L. Fitchett

2. Date of Death

Month

Day

Year

8

3

97

3. Time of Death

1508

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

5. Social Security Number

228-24-1265

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Nov. 17, 1927

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Virginia

10b. County

Accomack

10c. City, Town or Location

Chincoteague

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5017 Chicken City Road

10f. Zip Code

23336

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WW 11

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Waterman

16b. Kind of Business/Industry

Self

17. Father's Name (First, Middle, Last)

Judson C. Fitchett

18. Mother's Name (First, Middle, Maiden Surname)

Helen Birch

19a. Informant's Name/Relationship (Type, Print)

Helen S. Fitchett

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5017 Chicken City Road, Chincoteague, Virginia 23336

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mechanics Cemetery

Date

8-7-97

20c. Location - City or Town, State

Chincoteague, Virginia

21. Signature of Funeral Service Licensee

Eustace Selwyn Cook Bailey

22. Name and Address of Facility

Salter Funeral Home
Chincoteague, Virginia 23336

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Nicholas J. Dudas

29c. License number

D41567

29d. Date signed (Month, Day, Year)

8/3/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

145 E CARROLL ST. SALISBURY MD 21801

NICHOLAS J. DUDAS

31. Date filed (Month, Day, Year)

AUG 05 1997

32. Registrar's Signature

Julia [Signature]

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

1. The first part of the paper

is devoted to a general

introduction to the

subject of the paper.

2. The second part

of the paper

is devoted to a

discussion of the

results of the

investigation.

The third part of the

paper is devoted to a general

conclusion of the

investigation and a discussion

of the

results of the investigation.

The fourth part of the

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25025

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Erwin Vance Fellers

2. Date of Death

Month Day Year
AUGUST 3, 1997

3. Time of Death

12:00 PM

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL ASSN

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

330-16-2356

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

87

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Mar 29, 1910

9. Birthplace (State or Foreign Country)

Tennessee

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

407 Morningside Drive

10f. Zip Code

21061

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
Grade 3

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Starling Gentry

18. Mother's Name (First, Middle, Maiden Surname)

Virgie Shelton

19a. Informant's Name/Relationship (Type, Print)

Bill Fellers son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

407 Morningside Drive, Glen Burnie, Maryland 21061

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Memorial Pk

Date

8/6/97

20c. Location - City or Town, State

Dorsey, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Donaldson Funeral Home, P.A.
313 Talbott Ave. Laurel, Maryland 20707-4389

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Hyperosmolar Nonketotic Diabetic Coma

2 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Severe Dehydration with Hypernatremia

2 days

Due to (or as a consequence of):

c. Sepsis

2 days

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CVA, NIDDM, ASCVD

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

DU4973

29d. Date signed (Month, Day, Year)

Aug 3rd 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GURMEET S SAWHNEY, MD 325 Hospital Dr, Glen Burnie, Md 21061

31. Date filed (Month, Day, Year)

AUG 07 1997

32. Registrar's Signature

State
Registrar

FELLERS ERWIN

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25026

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|----------------------------------|--|---|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ELLIOTT HARVEY GLUNT | | | | | | 2. Date of Death Month Day Year AUG 02 1997 | | 3. Time of Death 02:30AM | |
| | 4a. Facility Name (If not institution, give street and number) NATIONAL NAVAL MEDICAL CENTER | | | | | | 4b. City, Town, or Location of Death BETHESDA | | 4c. County of Death MONTGOMERY | |
| Funeral Director | 5. Social Security Number 171-07-3971 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 85 Yrs. | | 8. Date of Birth (Month, Day, Year) OCT. 16, 1911 | | 9. Birthplace (State or Foreign Country) PENNSYLVANIA | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State MARYLAND | | 10b. County MONTGOMERY | | 10c. City, Town or Location SIVLER SPRING | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 10411 BRUNSWICK AVENUE | | 10f. Zip Code 20902 | | 10g. Citizen of What Country? U.S.A. | | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1941-1954 | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SECURITY ANALYST | | | | 16b. Kind of Business/Industry FEDERAL GOVERNMENT | | |
| 17. Father's Name (First, Middle, Last) WILLIAM E. GLUNT | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) ROXIE GIBBONEY | | | | |
| 19a. Informant's Name/Relationship (Type, Print) DAVID A. GLUNT | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10411 BRUNSWICK AVENUE SILVER SPRING, MARYLAND 20902 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) METROPOLITAN CREMATORY | | Date 8/3/97 | | 20c. Location - City or Town, State ALEXANDRIA, VIRGINIA | | |
| 21. Signature of Funeral Service Licensee | | | | | | 22. Name and Address of Facility FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W., SILVER SPRING, MD 20901 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. KIDNEY FAILURE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | |
| | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier | | | | | | 29c. License number 152590 (MA) | | 29d. Date signed (Month, Day, Year) 08/03/97 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S.MCINTYRE LT, MC, USN | | | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600 | | | | |
| 31. Date filed (Month, Day, Year) AUG 4 1997 | | | | | | 32. Registrar's Signature | | | | |

Baltimore, Maryland 21215-0020

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Reamend #10c, 8/6/97, BMW, Montg. Co per F.H.
Amend #7, 8/6/97, BMW, Montg. Co

State of Maryland / Department of Health and Mental Hygiene

97 25027

Amend #10c, 8/6/97, BMW, Montg. Co per F.H. Certificate of Death

Reg. No.

| | | | | | |
|---|---|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Marion Goodwin | | 2. Date of Death Month Aug. Day 2 Year 1997 | | 3. Time of Death 10:45 pm |
| | 4a. Facility Name (If not institution, give street and number) Manor Care- Bethesda | | 4b. City, Town, or Location of Death Chevy Chase | | 4c. County of Death Montgomery |
| Funeral Director | 5. Social Security Number 278.12.6666 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 94 93 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) March 6, 1903 | | 9. Birthplace (State or Foreign Country) Pennsylvania | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10a. State DC | | |
| | 10b. County | | 10c. City, Town or Location Chevy Chase Chevy Chase Washington | | |
| | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| | 10e. Street and Number 5304 Broadbranch Road | | 10f. Zip Code 20015 | | 10g. Citizen of What Country? U.S.A. |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: White | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Social Worker | | 16b. Kind of Business/Industry Social Work |
| | 17. Father's Name (First, Middle, Last) Frederick Schmadel | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Cronin | | |
| | 19a. Informant's Name/Relationship (Type, Print) Patricia Goodwin Norry/Daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8216 Kerry Road Chevy Chase, Md. 20815 | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery | | 20c. Location - City or Town, State 8/8/97 Silver Spring, Md. |
| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Joseph Gawler's Sons, Inc. 5130 WI AVE NW WDC 20015 | | | |
| Physician /Medical Examiner | 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | Approximate Interval Between Onset and Death Week |
| | Immediate Cause (Final disease or condition resulting in death) Urosepsis | | | | |
| | Due to (or as a consequence of): | | | | |
| | Due to (or as a consequence of): | | | | |
| | Due to (or as a consequence of): | | | | |
| | Due to (or as a consequence of): | | | | |
| | Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia of Alzheimers Type | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier | | 29c. License number D42403 | | 29d. Date signed (Month, Day, Year) Aug. 4, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) RAJ MATHUR, M.D. 5530 WISCONSIN AVENUE #1248 CHEVY CHASE, MD. 20815 | | | | | |
| 31. Date filed (Month, Day, Year) AUG 06 1997 | | 32. Registrar's Signature | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25028

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|--|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) LILLIAN GREENBERG | | | | 2. Date of Death Month Day Year AUGUST 07, 1997 | | 3. Time of Death 5:30AM | |
| | 4a. Facility Name (If not institution, give street and number) 3310 NORTH LEISURE WORLD BLVD. #220 | | | | 4b. City, Town, or Location of Death SILVER SPRING | | 4c. County of Death MONTGOMERY | |
| Funeral Director | 5. Social Security Number 166-03-5198 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 80 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) MARCH 27, 1917 | 9. Birthplace (State or Foreign Country) PENNSYLVANIA |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MARYLAND | | 10b. County MONTGOMERY | | 10c. City, Town or Location SILVER SPRING | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 3310 NORTH LEISURE WORLD BLVD. #220 | | | | 10f. Zip Code 20906 | | 10g. Citizen of What Country? UNITED STATES | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER | | | 16b. Kind of Business/Industry OWN HOME | |
| 17. Father's Name (First, Middle, Last) AARON FINKELMAN | | | | 18. Mother's Name (First, Middle, Maiden Surname) KATIE "UNKNOWN" | | | | |
| 19a. Informant's Name/Relationship (Type, Print) HARRIET ARLENE WEISS/DAUGHTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109 STRATFORD COURT, MOUNTAIN VIEW, CALIFORNIA 94040 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MENORAH GARDENS | | Date 8/8/97 | | 20c. Location - City or Town, State ROCKVILLE, MARYLAND | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death YEARS |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CONJESTIVE HEART FAILURE VALVULAR HEART DISEASE | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier | | 29c. License number D08381 | | 29d. Date signed (Month, Day, Year) AUGUST 7, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) AVRUNIN, BENJAMIN, MD 1811 PRINCE PHILLIP DRIVE #209, OLNEY, MARYLAND 20832-1513 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 08 1997 | | | | 32. Registrar's Signature | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

20

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25029

AMEND ITEM: #5 PER INFORMANT G783 5-26-00 WR *Certificate of Death*

Reg. No.

| | | | | | |
|--|---|--|---|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Celia K. Grossberg | | 2. Date of Death Month August Day 4 , Year 1997 | | 3. Time of Death 1:30am |
| | 4e. Facility Name (If not institution, give street and number) 9707 Old Georgetown Rd. | | 4b. City, Town, or Location of Death Bethesda | | 4c. County of Death Montgomery |
| Funeral Director | 5. Social Security Number 578-48-5802 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 93 Yrs. | If Under 1 Year Months 0 Days 0 | If Under 24 Hrs. Hours 0 Min. 0 |
| | 8. Date of Birth (Month, Day, Year) Sept. 10, 1903 | | 9. Birthplace (State or Foreign Country) New York | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10c. City, Town or Location | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10a. State Maryland | 10b. County Montgomery | Bethesda | | |
| | 10e. Street and Number 9707 Old Georgetown Rd. | | 10f. Zip Code 20814 | | 10g. Citizen of What Country? U.S.A. |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4or 5+) 2 | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bookkeeper | | 16b. Kind of Business/Industry Accounting Firm | | |
| | 17. Father's Name (First, Middle, Last) Jacob Kanster | | 18. Mother's Name (First, Middle, Maiden Surname) Pauline Berger | | |
| | 19a. Informant's Name/Relationship (Type, Print) Perla G. Fox | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5450 Whitley Park #801 Bethesda, MD 20814 | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Adas Israel Cemetery | | 20c. Location - City or Town, State Washington, D.C. |
| | 21. Signature of Funeral Service Licentiate | | 22. Name and Address of Facility Ives-Pearson Funeral Homes 2847 Wilson Blvd. Arlington, VA 22201 | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | Approximate Interval Between Onset and Death |
| | Immediate Cause (Final disease or condition resulting in death) RENAL FAILURE | | | | 100 days |
| | Due to (or as a consequence of): BROMELDGENIC CARCINOMA | | | | 8 Mon |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | | | | | 24e. Was an autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M |
| | | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | |
| | 29b. Signature and title of certifier | | 29c. License number DC1283 | | 29d. Date signed (Month, Day, Year) 8/4/97 |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARILE SILEN, MD 1145 19th St NW | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) AUG 06 1997 | | 32. Registrar's Signature | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

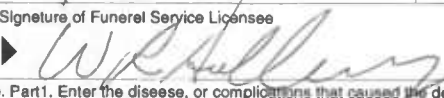
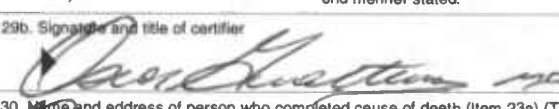
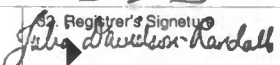
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25030

Certificate of Death

Reg. No.

| | | | | | |
|---|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JERRY ALLEN GAMBRILL | | 2. Date of Death Month August Day 3 Year 1997 | | 3. Time of Death 0450 |
| | 4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER | | 4b. City, Town, or Location of Death SALISBURY | | 4c. County of Death WICOMICO |
| Funeral Director | 5. Social Security Number 214-68-6733 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 40 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) April 13, 1957 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | |
| | 10a. State Maryland | 10b. County Wicomico | 10c. City, Town or Location Salisbury | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number 409 Moss Hill Lane, Apt. G | | 10f. Zip Code 21804 | | 10g. Citizen of What Country? USA |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) - | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Self Employed | | 16b. Kind of Business/Industry Construction | | |
| | 17. Father's Name (First, Middle, Last) Walter M. Gambrill | | 18. Mother's Name (First, Middle, Maiden Surname) Jacqueline Lankford | | |
| | 19a. Informant's Name/Relationship (Type, Print) Patricia Gambrill/Wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 409 Moss Hill La, Apt. G, Salisbury, MD 21804 | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Springhill Memory Gardens | | 20c. Location - City or Town, State Hebron, MD |
| | 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21804 | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Metastatic Lung Ca (Large cell) ~ 8 months Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypokalemia Aspiration Fluoride Jover | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | |
| | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier  | | 29c. License number 247619 | | 29d. Date signed (Month, Day, Year) 8/3/97 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES WALTERS MD 262 Tighman Rd, Salisbury MD 21804 | | | | | |
| 31. Date filed (Month, Day, Year) AUG 05 1997 | | | | | |
| 32. Registrar's Signature  | | | | | |

B.K.S

RALPH LEO GOLDSMITH

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25031

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|--|---|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Ralph Leo Goldsmith | | | | 2. Date of Death Month Day Year AUG. 06, 1997 | | 3. Time of Death 0707AM | |
| | 4a. Facility Name (If not institution, give street and number) 6769 AMHERST ROAD | | | | 4b. City, Town, or Location of Death Bryans Road | | 4c. County of Death CHARLES | |
| Funeral Director | 5. Social Security Number 219-16-0241 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 73 Yrs. | | 8. Date of Birth (Month, Day, Year) Jan. 20, 1924 | |
| | 9. Birthplace (State or Foreign Country) MD | | 10a. State MD | | 10b. County Charles | | 10c. City, Town or Location Bryans Road | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 6769 Amherst Rd. | | 10f. Zip Code 20616 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Ordance Worker | | 16b. Kind of Business/Industry U.S. Government | | | | |
| 17. Father's Name (First, Middle, Last) John T. Goldsmith | | | | 18. Mother's Name (First, Middle, Maiden Surname) Grace L. Ryce Goldsmith | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Joyce Hill/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10600 Mahogany Ct. Waldorf, MD 20601 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Christ Church Cem. | | Date 8/11/97 | | 20c. Location - City or Town, State Wayside, MD | | |
| 21. Signature of Funeral Service Licensee David C. Elch M00945 | | | | 22. Name and Address of Facility AREHART-ECHOLS FUNERAL HOME, INC. P.O. Box 567 LaPlata, MD 20646 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Intra-Oral Gunshot Wound Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. Prostate cancer | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) 8/6/97 | | 28b. Time of Injury ~ 700A M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred self-inflicted gunshot wound | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) 6769 Amherst Rd Bryans Rd, Md | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Dennis J. Chute, MD | | | | | | | | |
| 29b. Signature and title of certifier Dennis J. Chute, MD | | 29c. License number O.C.M.E | | 29d. Date signed (Month, Day, Year) AUG. 7, 1997 | | | | |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) Dennis J. Chute, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 11 1997 | | 32. Registrar's Signature John Andrew Randall | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25032

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) James K. Guthrie | | | | 2. Date of Death Month 08 Day 04 Year 97 | | 3. Time of Death 4:25AM | |
| | 4a. Facility Name (If not institution, give street and number) Maryland Masonic Homes | | | | 4b. City, Town, or Location of Death Cockeysville | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 230-07-6349 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 80 Yrs. | | 8. Date of Birth (Month, Day, Year) December 13, 1916 | |
| | 9. Birthplace (State or Foreign Country) Virginia | | 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Cockeysville | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 300 International Circle | |
| | 10f. Zip Code 21030 | | | | 10g. Citizen of What Country? U.S.A. | | | |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Retail Salesman | | 16b. Kind of Business/Industry Department Store | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Jesse C. Guthrie | | | | 18. Mother's Name (First, Middle, Maiden Summa) Ila J. Thomas | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Barry Drew/Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 204 David Drive, Chestertown, Maryland 21620 | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Chester Cemetery/August 8, 1997 | | 20c. Location - City or Town, State Chestertown, Maryland | | 21. Signature of Funeral Service Licensee <i>Gay B. Sellers</i> | |
| | 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Congestive heart failure</u> Due to (or as a consequence of): b. <u>mitral stenosis</u> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death 1 month | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier <i>June Breiner MD</i> | | 29c. License number D40208 | |
| | 29d. Data signed (Month, Day, Year) 8/4/97 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) June Breiner MD 1205 York Rd Ste 32C Lutherville Md 21093 | | 31. Date filed (Month, Day, Year) AUG 07 '97 | | | |
| State Registrar | 32. Registrar's Signature <i>Julia Davidson-Randall</i> | | | | 33. Date of filing (Month, Day, Year) AUG 07 '97 | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25033

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) John Haffner | | | | 2. Date of Death Month August Day 7 Year 1997 | | 3. Time of Death 3:20AM | |
| | 4a. Facility Name (If not institution, give street and number) Care Matrix Nursing Center | | | | 4b. City, Town, or Location of Death Silver Spring | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 578-32-5361 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 72 Yrs. | | 8. Date of Birth (Month, Day, Year) Sept. 9, 1924 | |
| | 9. Birthplace (State or Foreign Country) Washington, D.C. | | 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Silver Spring | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 413 East Wayne Avenue | | 10f. Zip Code 20901 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Duplicator | | 16b. Kind of Business/Industry Photographic | | | |
| | 17. Father's Name (First, Middle, Last) Erich Haffner | | | | 18. Mother's Name (First, Middle, Maiden Surname) Pearl Lawson | | | |
| Physician /Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Betty Lee Burns | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 413 East Wayne Avenue Silver Spring, Maryland 20901 | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory | | Date 8/7/97 | | 20c. Location - City or Town, State Alexandria, Virginia | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee <i>William L. Byrd</i> | | | | 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Bronchogenic Carcinoma with metastasis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. c. d. Due to (or as a consequence of): Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death 1 yr | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. malnutrition, Pleural Effusion | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how Injury occurred | | | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | 29b. Signature and title of certifier <i>Antonio A. Uy mo</i> | |
| To Be Completed by Physician/Medical Examiner | 29c. License number D15146 | | | | | | 29d. Date signed (Month, Day, Year) 8/7/97 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 354 University Blvd W. Silver Spring, Md 20901 | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 31. Date filed (Month, Day, Year) AUG 08 1997 | | | | | | 32. Registrar's Signature <i>John Davidson-Randall</i> | |
| | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25034

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Evelyn G. Harrell

2. Date of Death

August

Day

4

Year

1997

3. Time of Death

1:15 p.m.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Manor Care - Bethesda

4b. City, Town, or Location of Death

Chevy Chase

4c. County of Death

Montgomery

5. Social Security Number

212.66.6120

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Feb. 8, 1909

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Chevy Chase

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8700 Jones Mill Road

10f. Zip Code

20815

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

+4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

William Edward Glenn

18. Mother's Name (First, Middle, Maiden Surname)

Monnie Johnston

19a. Informant's Name/Relationship (Type, Print)

Linwood Parker Harrell, Jr./Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4920 Palisade Lane N.W. Washington DC 20016

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Comfort Crematory

Date

8/6/97

20c. Location - City or Town, State

Alexandria, Va.

21. Signature of Funeral Service Licensee

Joseph Gawler's Sons Inc.

22. Name and Address of Facility

5130 WI AVE NW WDC 20016

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. CVA

Due to (or as a consequence of):

2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Alzheimer's Disease

Due to (or as a consequence of):

7 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

W. J. Tab Moore

29c. License number

2272

29d. Date signed (Month, Day, Year)

Aug. 5, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W. Tabb Moore, M. D. 1145 19th Street N.W. Washington, D. C. 20036-3781

31. Date filed (Month, Day, Year)

AUG 07 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

AM
DARNELL
HARRIS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25035

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|---|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) DARNELL T. HARRIS | | | | 2. Date of Death Month Day Year JULY 30, 1997 | | 3. Time of Death 1914 P | |
| | 4a. Facility Name (If not institution, give street and number) 3900 MILLFORD MILL RD. | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death BALTIMORE | |
| Funeral Director | 5. Social Security Number 220-02-9467 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 24 Yrs. | | 8. Date of Birth (Month, Day, Year) June 17, 1973 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State MD | | 10b. County Howard | | 10c. City, Town or Location Ellicott City | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 3594 Conchita Drive | | 10f. Zip Code 21043 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> 2 yrs | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Telephone Contractor | | 16b. Kind of Business/Industry Garvey Construction | | | |
| | 17. Father's Name (First, Middle, Last) Joseph R. Harris | | | | 18. Mother's Name (First, Middle, Maiden Surname) Cecilia Y. Wooden | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Cecilia Y. Harris (Mother) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3578 Court House Dr., Ellicott City, MD 21043 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Hopkins Church Cem. | | 20c. Date 8/9/97 | | 20d. Location - City or Town, State Highland, MD | |
| | 21. Signature of Funeral Service Licensee <i>George R. Snowden</i> | | | | 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Drowning Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| Physician /Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) WATER | | | | | | | |
| | 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 7-30-97 | | 28b. Time of Injury 1800M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28d. Describe how Injury occurred subject drowned | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) 3900 Millford Mill Baltimore County, Maryland | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| | 29b. Signature and title of certifier <i>Stephen S. Radentz, MD</i> | | | | 29c. License number OCME | | 29d. Date signed (Month, Day, Year) JULY 31, 1997 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| | 31. Date filed (Month, Day, Year) AUG 06 1997 | | | | 32. Registrar's Signature <i>John M. Radentz</i> | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25036

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Meryem Hasar

2. Date of Death
Month Day Year

August 1, 1997

3. Time of Death

7:15 PM

4a. Facility Name (If not institution, give street and number)

11907 Parklawn Drive #204

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

216-98-1108

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

January 1, 1904

9. Birthplace (State or Foreign Country)

Turkey

Usual Residence of Decedent

10e. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11907 Parklawn Drive #204

10f. Zip Code

20852

10g. Citizen of What Country?

Turkey

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

18e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Khachadur Khachadurian

18. Mother's Name (First, Middle, Maiden Surname)

Hatun (Not Available)

19e. Informant's Name/Relationship (Type, Print)

Ozzie Ozkanian

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20852
11925 Parklawn Drive #303, Rockville, Maryland

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)August 4, 1997
Gate of Heaven Cemetery

Date

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

M00846

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc.
7557 Wisconsin Avenue, Bethesda, Maryland 20814-350123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause in each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Renal Failure-Uremia

Due to (or as a consequence of):

2 Months

Sequitely list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Arteriosclerosis

Due to (or as a consequence of):

10 Years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Heart Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24e. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28e. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury et
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D10933

29d. Date signed (Month, Day, Year)

August 3, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Irene G. Tamagna, M.D., 7101 Connecticut Avenue, Chevy Chase, Maryland 20815

31. Date filed (Month, Day, Year)

AUG 4 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25037

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mildred P. Hawthorne

2. Date of Death

Month Day Year
July 30, 1997

3. Time of Death

2:15 AM

4a. Facility Name (If not institution, give street and number)

Gladys Spellman Nursing Care Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

5. Social Security Number

579-40-7643

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug. 14, 1924

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6319 23rd Avenue

10f. Zip Code

20782

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
White15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Legal

17. Father's Name (First, Middle, Last)

Lawrence J. Petrey

18. Mother's Name (First, Middle, Maiden Surname)

Mildred C. Herrity

19a. Informant's Name/Relationship (Type, Print)

James Hawthorne

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6319 23rd Avenue Hyattsville, Maryland 20782

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

8/4/97

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Acute and Chronic Pneumonitis

Due to (or as a consequence of):

Days

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Cancer and Chronic Lung Disease

Due to (or as a consequence of):

Years

c. Bronchiogenic Carcinoma and Chronic Obstructive

Due to (or as a consequence of):

Years

d. Lung Disease

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D05401

29d. Date signed (Month, Day, Year)

July 30, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

James W. Harding, M.D. 7525 Greenway Center Drive #316 Greenbelt, Maryland 20770

31. Date filed (Month)

AUG 06 1997

32. Registrar's Signature

1
10State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.


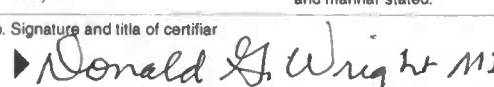
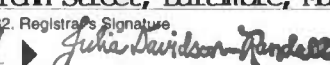
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25038

Amend #4b,9,18, 8/6/97,EMW, Montg. Co

| | | | | | | | | |
|--|--|--|---|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) CHRISTOPHER A. HICKS | | | | 2. Date of Death Month Day Year JULY 25, 1997 | | 3. Time of Death 12:03 P | |
| | 4a. Facility Name (If not institution, give street and number) 5802 ANNAPOLIS ROAD | | | | 4b. City, Town, or Location of Death BLADENSBURG | | 4c. County of Death PRINCE GEORGES | |
| Funeral Director | 5. Social Security Number 220-94-6484 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 34 Yrs. | | 8. Date of Birth (Month, Day, Year) MAY 19, 1963 | |
| | 9. Birthplace (State or Foreign Country) Wash. D.C. | | 10. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collage (1-4or 5+) Collage | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MAINTENANCE | |
| | 10a. State MD. | | 10b. County PRINCE GEORGES | | 10c. City, Town or Location BLADENSBURG | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number 5802 ANNAPOLIS RD. #512 | | | | 10f. Zip Code 20710 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | 15. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MAINTENANCE | | 16b. Kind of Business/Industry FT. MEADE EMPLOYMENT SERVICE | |
| | 17. Father's Name (First, Middle, Last) JOHN HICKS | | | | 18. Mother's Name (First, Middle, Maiden Surname) Ann Dutton | | | |
| | 19a. Informant's Name/Relationship (Type, Print) JOHN HICKS/FATHER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 1015, CHESTER, VA. 23831 | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) CHAMBERS CREMATORY | | 20c. Location - City or Town, State 8/6/97 RIVERDALE, MD. | |
| | 21. Signature of Funeral Service Licensee  W. H. Chambers MD00091 | | | | 22. Name and Address of Facility CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SEIZURE DISORDER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | |
| | | | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier  Donald G. Wright MD | | | | |
| | | | | 29c. License number OCME | | 29d. Date signed (Month, Day, Year) AUGUST 04, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Donald G. Wright M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 06 1997 | | | | 32. Registrar's Signature  John Davidson-Randall | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25039

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ALICE LEE HARMON

2. Date of Death

July 28, 1997

3. Time of Death

1951

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral
Director

5. Social Security Number

214-32-6673

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

64 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JAN. 16, 1933

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

WICOMICO

10c. City, Town or Location

WILLARDS

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6986 BENT PINE ROAD

10f. Zip Code

21874

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

LOAN PROCESSOR

16b. Kind of Business/Industry

BANKING

17. Father's Name (First, Middle, Last)

JOHN ETCHER COOPER

18. Mother's Name (First, Middle, Maiden Surname)

MAGGIE P. WILKINS

19a. Informant's Name/Relationship (Type, Print)

HERBERT L. HARMON/HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6986 BENT PINE ROAD, WILLARDS, MARYLAND 21874

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

COOPER CEMETERY

Date

7/31/97

20c. Location - City or Town, State

WILLARDS, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HASTINGS FUNERAL HOME, SELBYVILLE, DELAWARE 19975

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)a. metastatic Small Cell Lung Cancer
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes X No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D 20507

29d. Date signed (Month, Day, Year)

7/30/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph A. Grasso 145 E. Carroll St Salisbury MD 21801

State
Registrar

31. Date filed (Month, Day, Year)

AUG 01 1997

32. Registrar's Signature

John Davidson-Randall

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Alice Harmon - 214-32-6673
Baltimore, Maryland 21215-0020

98063

THE UNIVERSITY OF CHICAGO
LIBRARY
540 EAST 58TH STREET
CHICAGO, ILL. 60637

THE UNIVERSITY OF CHICAGO
LIBRARY
540 EAST 58TH STREET
CHICAGO, ILL. 60637

THE UNIVERSITY OF CHICAGO
LIBRARY
540 EAST 58TH STREET
CHICAGO, ILL. 60637

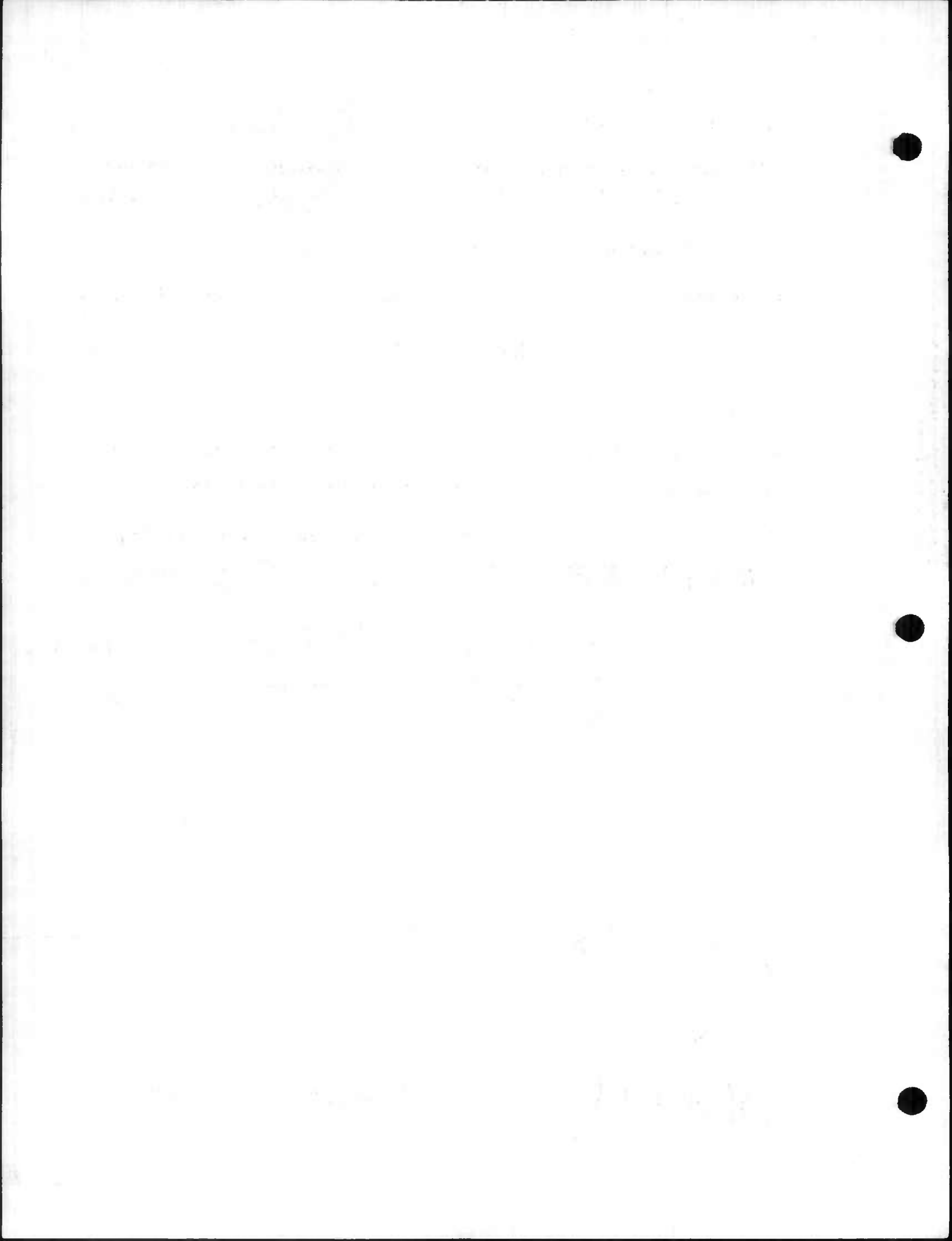
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25040

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|--|--|--|---|---|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Carroll Richard Humler | | | | 2. Date of Death Month Day Year August 3, 1997 | | 3. Time of Death 0058 | | |
| | 4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER | | | | 4b. City, Town, or Location of Death SALISBURY | | 4c. County of Death WICOMICO | | |
| Funeral Director | 5. Social Security Number 218-20-6040 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 69 Yrs. | | 8. Date of Birth (Month, Day, Year) 3-16-28 | | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State MD | | 10b. County Wicomico | | 10c. City, Town or Location Salisbury | | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 28910 Naylor Mill Road | | 10f. Zip Code 21801 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: '45-47 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collega (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | | 16b. Kind of Business/Industry | | | | | |
| 17. Father's Name (First, Middle, Last) John George Humler | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mamie Carol Gardner Humler | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) JoAnn Humler | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28910 Naylor Mill Rd. Salisbury, MD 21801 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Eastern Shore Veterans 8-6-97 Beulah, MD | | 20c. Location - City or Town, State | | | | | |
| 21. Signature of Funeral Service Licensee Michael F. Eskow | | 22. Name and Address of Facility Frampton-Hawkins-Eskow Funeral Home 216 North Main St. Federalsburg, MD | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e. Acute Myocardial Infarction Due to (or as a consequence of): b. Coronary Artery Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | Approximate Interval Between Onset and Death Hours | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier [Signature] | | 29c. License number D34768 | | 29d. Date signed (Month, Day, Year) 8/3/97 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 560 Riverside Dr. B01 Salisbury, MD 21801 | | 31. Date filed (Month, Day, Year) AUG 05 '97 | | 32. Registrar's Signature [Signature] | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25041

Certificate of Death

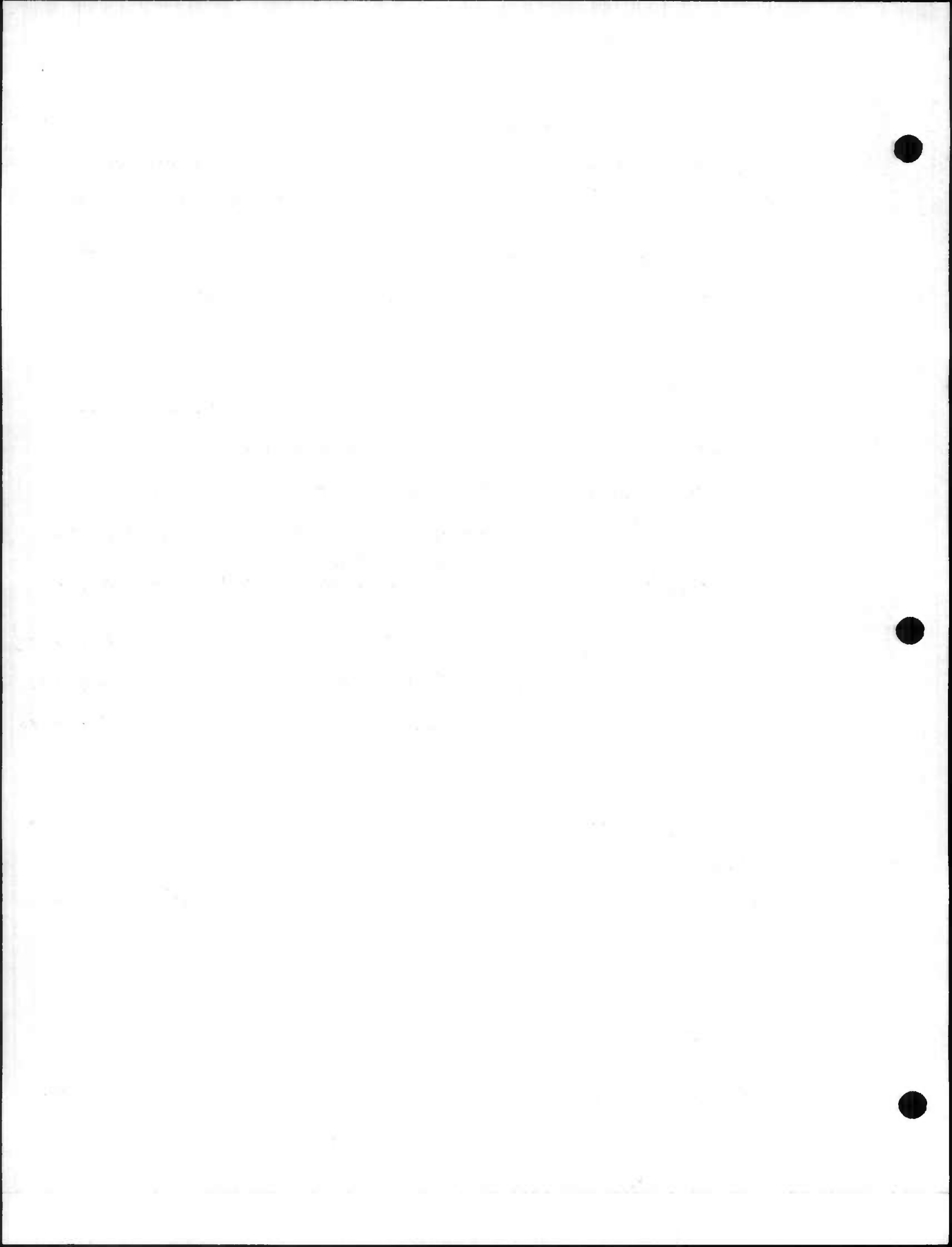
Reg. No.

| | | | | | | | | | | |
|-------------------------------------|---|--|--|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Elizabeth Hazer | | | | 2. Date of Death Month August Day 06 , Year 1997 | | | | 3. Time of Death 3:30 pm | |
| | 4a. Facility Name (If not institution, give street and number) Montgomery General Hospital | | | | 4b. City, Town, or Location of Death Olney | | | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 168-07-1716 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 85 Yrs. | | 8. Date of Birth (Month, Day, Year) Mar 05, 1912 | | 9. Birthplace (State or Foreign Country) Pennsylvania | |
| | Usual Residence of Decedent | | | | 10a. State MD | | 10b. County Montgomery | | 10c. City, Town or Location Olney | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 10e. Street and Number 2 Ashland Brooke Court | | | | 10f. Zip Code 20832 | |
| | 10g. Citizen of What Country? USA | | | | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Assembler | | | | 16b. Kind of Business/Industry Toy Manufacturer | | | | 17. Father's Name (First, Middle, Last) John Groff | |
| | 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Egett | | | | 19a. Informant's Name/Relationship (Type, Print) Nancy Rodewald/daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 488 Moroe Boulevard, Painesville, Ohio 44077 | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St. John's Cemetery | | | | 20c. Location - City or Town, State 8/11/97 Girard, Pennsylvania | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389 | | | | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pulmonary Edema Due to (or as a consequence of): b. Coronary Artery Disease Due to (or as a consequence of): c. Broncho spasm Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | |
| | 28a. Date of Injury (Month, Day Year) | | | | 28b. Time of Injury M | | | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| Physician /Medical Examiner | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier Dawn A. L. Broderick | | | | 29c. License number D45956 | |
| | 29d. Date signed (Month, Day, Year) August 6, 1997 | | | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dawn Broderick 18111 Prince Phillip Dr, T12 Olney, MD 20832 | | | | 31. Date filed (Month, Day, Year) AUG 07 1997 | |
| | 32. Registrar's Signature | | | | 33. Date of Death August 06, 1997 | | | | 34. Time of Death 3:30 pm | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar



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State of Maryland / Department of Health and Mental Hygiene

97 25042

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Fred B. Johnson

2. Date of Death

Month Day Year
August 4, 1997

3. Time of Death

8:21AM

4a. Facility Name (If not institution, give street and number)

Rockville Nursing Home

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

578-01-2809

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

87

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 27, 1910

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

4413 Chestnut Street

10f. Zip Code

20814

10g. Citizen of What Country?

United States

11. Marital Status

☐ Navar Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No World

If Yes, Give Year or Dates: War II

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

Self Employed

17. Father's Name (First, Middle, Last)

William Otha Johnson, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Lillie Rebecca Knott

19a. Informant's Name/Relationship (Type, Print)

Ada L. Windsor/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6 Maryland Avenue, Rockville, Maryland 20850-2312

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Parklawn Memorial Park

Date

August 7, 1997

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

David E. Perry M00803

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/

Rockville, Inc. 300 West Montgomery Avenue

Rockville, Maryland 20850-2805

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Cancer-Prostate

Due to (or as a consequence of):

with diffused metastasis

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOAOther: ☒☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☐ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending☐ Investigation☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

28d. Describe how injury occurred

☐ Yes ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Frauke Westphal

29c. License number

D19785

29d. Date signed (Month, Day, Year)

August 4th 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frauke Westphal, M.D. 809 Veirs Mill Road, #101, Rockville, Maryland 20851-1689

31. Date filed (Month, Day, Year)

AUG 07 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25043

Amend #7&#8, 8/8/97, BMW, Montg. Co.

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SARAH

2. Date of Death
Month Day Year

JOHNSON

August 2, 1997

3. Time of Death

7:13 PM

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

577-60-5075

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 ~~82~~ Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

Oct. 27, 1914

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5406 14th Ave.

10f. Zip Code

20782

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Bookkeeper

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

John Blish

18. Mother's Name (First, Middle, Maiden Surname)

Ida Gurney

19a. Informant's Name/Relationship (Type, Print)

Albert Johnson/husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5406 14th Ave. Hyattsville, MD 20782

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metropolitan Crematory Aug. 5, 1997 Alexandria, VA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Takoma Funeral Home, Inc.
254 Carroll St. NW Washington, DC 2001223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)e. SEPSIS
Due to (or as a consequence of):Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Lastb. SEPTICEMIA
Due to (or as a consequence of):c. CARDIO-PULMONARY ARREST
Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☒ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

15820

29d. Date signed (Month, Day, Year)

8/3/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

HONG L. TEE and 3405 Hamilton St Hyattsville MD 20782

31. Date filed (Month, Day, Year)

AUG 05 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
permit.

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25044

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GUYMAN F. JONES

2. Date of Death

August 5, 1997

3. Time of Death

5:47 AM

4a. Facility Name (If not institution, give street and number)

LAUREL REGIONAL HOSPITAL

4b. City, Town, or Location of Death

LAUREL

4c. County of Death

PRINCE GEORGES

Funeral
Director

5. Social Security Number

578 42 5905

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

67

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 4, 1930

9. Birthplace (State or Foreign Country)

TENNESSEE

Usual Residence of Decedent

10a. State

MD.

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

14921 PEACH ORCHARD ROAD

10f. Zip Code

20905

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates: 1951-

1953

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

0

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CARPENTER

16b. Kind of Business/Industry

CONSTRUCTION

17. Father's Name (First, Middle, Last)

OBA ODD JONES

18. Mother's Name (First, Middle, Maiden Surname)

IDA MAE RICKER

19. Informant's Name/Relationship (Type, Print)

SAMUEL N. JONES, BROTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2608 MONOCACY BOTTOM ROAD, ADAMSTOWN, MD. 21710

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

LAYTONSVILLE CEMETERY

Date

8/9/97

20c. Location - City or Town, State

LAYTONSVILLE, MD.

21. Signature of Funeral Service Licensee

Muriel H. Barber

22. Name and Address of Facility

MURIEL H. BARBER FUNERAL HOME
P.O. BOX 5038, LAYTONSVILLE, MD. 20882

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

METASTATIC OAT CELL LUNG CANCER

Approximate Interval Between Onset and Death

3 MONTHS

Immediate Cause (Final disease or condition resulting in death)

e. Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☒ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOAOther: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending Investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Thomas A. Beninger MD

29c. License number

D 08754

29d. Date signed (Month, Day, Year)

AUGUST 5, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. THOMAS A. BENINGER, 7525 GREENWAY CIRCLE DRIVE, GREENBELT, MD. 20770

31. Date filed (Month, Day, Year)

AUG 07 1997

32. Registrar's Signature

John Davidson-Rendell

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25045

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Cheryl Lee Judy | | | | 2. Date of Death Month August Day 3 Year 1997 | | 3. Time of Death 5:51 PM | |
| | 4a. Facility Name (If not institution, give street and number) Union Memorial Hospital | | | | 4b. City, Town, or Location of Death Baltimore City | | 4c. County of Death | |
| Funeral Director | 5. Social Security Number 213-66-3481 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 40 Yrs. | | 8. Date of Birth (Month, Day, Year) Sep. 15, 1956 | |
| | 9. Birthplace (State or Foreign Country) Washington, D.C. | | 10a. State Maryland | | 10b. County Baltimore City | | 10c. City, Town or Location Baltimore City | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 3205 Guilford Avenue | | 10f. Zip Code 21012 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input checked="" type="checkbox"/> Navar Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Unemployed | | 16b. Kind of Business/Industry | | 16c. Kind of Business/Industry | |
| | 17. Father's Name (First, Middle, Last) Robert Lee Judy | | 18. Mother's Name (First, Middle, Maiden Surname) Julia Barna | | 19a. Informant's Name/Relationship (Type, Print) Judy A. Reitz / Sister | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13005 Jerome Jay Drive, Cockeysville, MD 21030 | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cem. | | 20c. Location - City or Town, State 8/11/97 Arlington, Virginia | | 20d. Location - City or Town, State | |
| | 21. Signature of Funeral Service Licensee Alan J. Donnell | | 22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Acute Fulminant Liver Failure Due to (or as a consequence of): | | Approximate Interval Between Onset and Death 4 days | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Hepatic Coma Due to (or as a consequence of): | | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 23d. Describe how injury occurred | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Metabolic Acidosis Due to (or as a consequence of): | | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 23d. Describe how injury occurred | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Chronic Alcoholic Liver Dysfunction Due to (or as a consequence of): | | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 23d. Describe how injury occurred | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 23d. Describe how injury occurred | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | |
| | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Julia Davidson-Randall M.D. | | 29c. License number AT 2439846 | | 29d. Date signed (Month, Day, Year) August 3, 1997 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANY SHAMOUN, M.D. Union Memorial Hospital | | 31. Date filed (Month, Day, Year) AUG 08 1997 | | 32. Registrar's Signature Julia Davidson-Randall | | | |
| | 31. Date filed (Month, Day, Year) AUG 08 1997 | | 32. Registrar's Signature Julia Davidson-Randall | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 25046**
Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|--|--------------------------------|---|---|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Gloria Ovella Johnson | | | | | 2. Date of Death Month August Day 03 Year 1997 | | 3. Time of Death 09:30 am | |
| | 4a. Facility Name (If not institution, give street and number) 508 S. Main St. | | | | | 4b. City, Town, or Location of Death Hebron | | 4c. County of Death Wicomico | |
| Funeral Director | 5. Social Security Number 216-38-9769 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 57 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Feb 14, 1940 | | 9. Birthplace (State or Foreign Country) MD |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State MD | | 10b. County Wicomico | | 10c. City, Town or Location Hebron | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 10e. Street and Number 508 S. Main St. | | | | 10f. Zip Code 21830 | | 10g. Citizen of What Country? U.S. | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Collage (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Day Care Provider | | | 16b. Kind of Business/Industry Private Duty | | |
| 17. Father's Name (First, Middle, Last) Preston Sylvester Morris | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Dorothy Williams | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Johanna Johnson/daughter | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 508 S. Main St., Hebron, MD 21830 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Springhill Memory Gardens | | 20c. Location - City or Town, State Salisbury, MD | | 20d. Date 8/9/97 | | |
| 21. Signature of Funeral Service Licenses M01070 | | | | | 22. Name and Address of Facility Calvin L. Williams Funeral Services 270 Fredhilton Pass, Baltimore, MD 21229 | | | | |
| 23a. Part i. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Metastatic Colon Cancer</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | Approximate Interval Between Onset and Death 5 yrs |
| Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | | | 28d. Describe how Injury occurred | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier MD | | | | | 29c. License number D26278 | | 29d. Date signed (Month, Day, Year) 8-6-97 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David F. Carroll, MD 145 E. Carroll St. Salisbury, MD 21801 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 06 1997 | | | 32. Registrar's Signature | | | | | | |

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25047

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|--|--|---|--|---|--|--|--|-----------------------------------|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Caroline Judge | | | 2. Date of Death Month Day Year 08 05 97 | | 3. Time of Death 12 midnight | | | |
| | 4a. Facility Name (If not institution, give street and number) Caroline Nursing Home, Inc. | | | 4b. City, Town, or Location of Death Denton | | 4c. County of Death Caroline | | | |
| Funeral Director | 5. Social Security Number 191-22-6899 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 89 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) December 23, 1907 | 9. Birthplace (State or Foreign Country) Pennsylvania | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Pennsylvania | | 10b. County Media | | 10c. City, Town or Location Springfield | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | 10e. Street and Number 331 East Leamy Avenue | | | 10f. Zip Code 19064 | | 10g. Citizen of What Country? United States | | | |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Caucasian | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Home | | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) John Mahler | | | | 18. Mother's Name (First, Middle, Maiden Surname) Madeline Huhd | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) John M. Judge Son | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 Brinsfield Avenue, Seaford, Delaware 19973 | | | | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Moriah Cemetery | | Date 8/9/97 | | 20c. Location - City or Town, State Philadelphia, Pennsylvania | | |
| | 21. Signature of Funeral Service Licensee <i>Randolph P. Chare</i> | | 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629 | | | | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Gastrointestinal bleed 1 day Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia Hypertension | | | | | | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier <i>J. Sides MD</i> | | 29c. License number D31376 | | 29d. Date signed (Month, Day, Year) 8-5-97 | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James Sides 920 Market St Denton | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 31. Date filed (Month, Day, Year) AUG 06 '97 | | 32. Registrar's Signature <i>Julia Davidson-Randall</i> | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25048

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|--|---|--|--|---|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Frank C. Johnson | | | | 2. Date of Death Month August Day 1 Year 1997 | | 3. Time of Death 5:00pm | | |
| | 4e. Facility Name (If not institution, give street and number) 3576 Lowlen Court | | | | 4b. City, Town, or Location of Death Ellicott City | | 4c. County of Death Howard | | |
| Funeral Director | 5. Social Security Number 399-24-7780 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 68 Yrs. | | 8. Date of Birth (Month, Day, Year) Dec 19, 1928 | | |
| | 9. Birthplace (State or Foreign Country) Wisconsin | | 10a. State Maryland | | 10b. County Howard | | 10c. City, Town or Location Ellicott City | | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 3576 Lowlen Court | | 10f. Zip Code 21042 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Salesman | | 16b. Kind of Business/Industry Retail | | 17. Father's Name (First, Middle, Last) Charles Johnson | | 18. Mother's Name (First, Middle, Maiden Surname) Florence Prescott | |
| 19a. Informant's Name/Relationship (Type, Print) Barbara L. Johnson/Wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3576 Lowlen Court Ellicott City, Maryland 21042 | | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Balt-Washington Crematory | | 20c. Location - City or Town, State Laurel, Maryland | |
| 21. Signature of Funeral Service Licensee Sharon A. Collins-Witzke | | 22. Name and Address of Facility Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Non Small cell Lung Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death 9 months | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Janet Cooper MD | | 29c. License number D46118 | | 29d. Date signed (Month, Day, Year) Aug 3, 1997 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 1447 York Rd Lutherville MD 21093 | | 31. Date filed (Month, Day, Year) AUG 04 1997 | | 32. Registrar's Signature John A. Russell | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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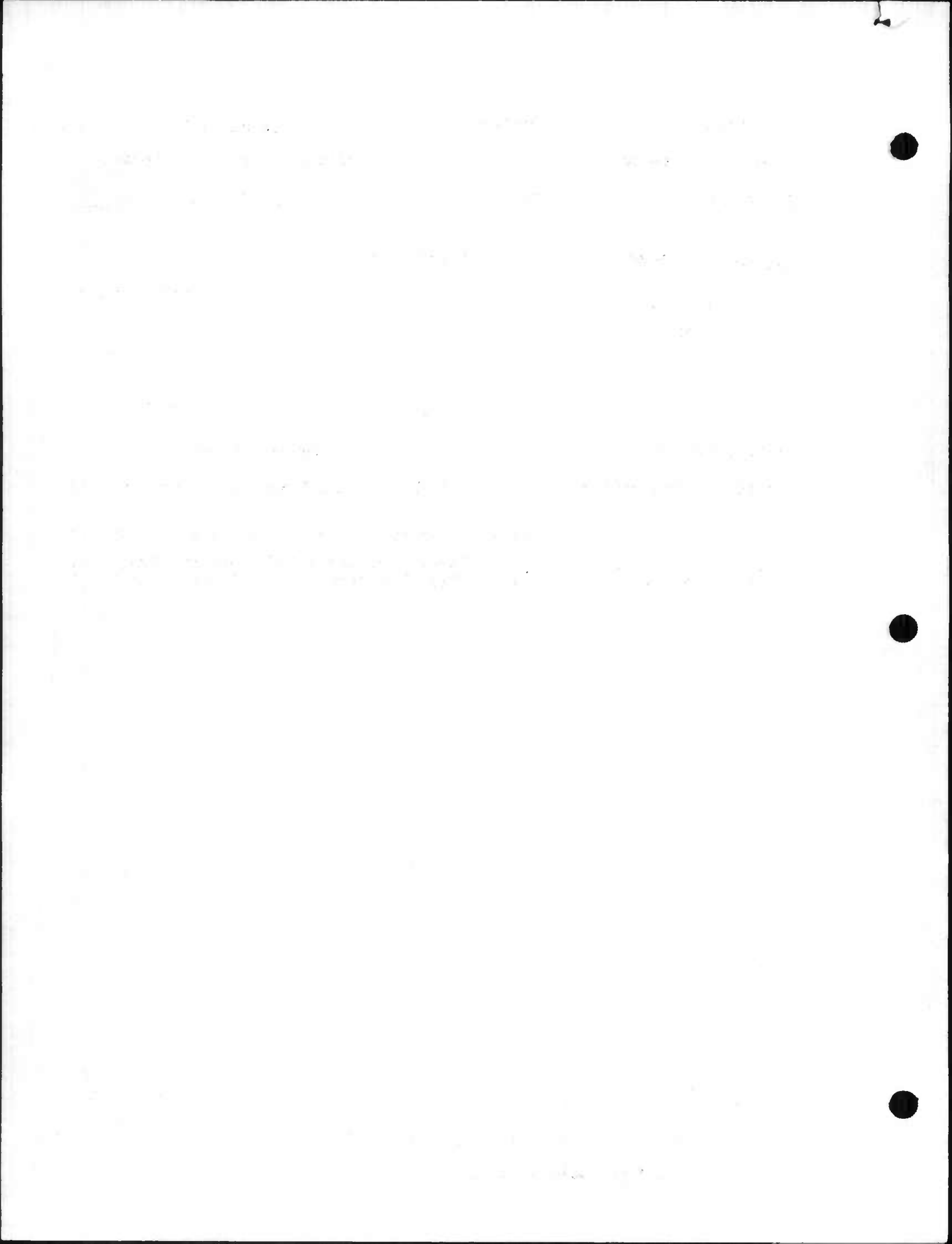
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25049

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|---|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Randolph Waddell Johnson | | | | 2. Date of Death Month 7- Day 28- Year 1997 | | 3. Time of Death 10:45 AM | |
| | 4a. Facility Name (If not institution, give street and number) 7511 Quaker Neck Rd. | | | | 4b. City, Town, or Location of Death Chestertown | | 4c. County of Death Kent | |
| Funeral Director | 5. Social Security Number 215-20-2133 | | 8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 71 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 6. Date of Birth (Month, Day, Year) 7-3-1926 | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Md. | | 10b. County Kent | | 10c. City, Town or Location Chestertown | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number 7511 Quaker Neck Rd. | | | | 10f. Zip Code 21620 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW11 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4 or 5+) (0 11) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance Supervisor | | 18b. Kind of Business/Industry A.R. Realtor | |
| | 17. Father's Name (First, Middle, Last) Simmon Barrett | | | | 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Taylor | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Mrs. Eloise Johnson (Wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 445 Chestertown, Maryland 21620 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Jane U.M. Cemetery | | Date 8/2/97 | | 20c. Location - City or Town, State Chestertown, Md. | |
| | 21. Signature of Funeral Service Licensee <i>[Signature]</i> M00510 | | | | 22. Name and Address of Facility WALLEY FUNERAL HOME 207 Calvert St. Chestertown, Md. 21620 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Cancer of Colon with Metastasis</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death <i>1 year</i> | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>① CVA ② Hypertension</i> | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier <i>[Signature]</i> M.D. | | | | 29c. License number 221313 | | 29d. Date signed (Month, Day, Year) 7/30/97 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kin Kue Wun M.D. 223 High Street Chestertown, Maryland 21620 | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) JUL 31 '97 | | 32. Registrar's Signature <i>[Signature]</i> | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

97 25050

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | |
|--|--|--|--|---|--------------------------------|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Lorraine Kalmans | | | | 2. DATE OF DEATH MONTH DAY YEAR July 28, 1997 | | 3. TIME OF DEATH 5:10 P M | |
| 4. SOCIAL SECURITY NUMBER 577-20-5398 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 77 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) March 30, 1920 | |
| 8. BIRTHPLACE (State or Foreign Country) NEW YORK | | | | 9a. FACILITY NAME (If not institution, give street and number) Manor Care Health Services | | 9b. CITY, TOWN OR LOCATION OF DEATH Wheaton | |
| 9c. COUNTY OF DEATH Montgomery | | | | RESIDENCE OF DECEDENT | | | |
| 10a. STATE Maryland | | 10b. COUNTY Montgomery | | 10c. CITY, TOWN OR LOCATION Wheaton | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 11901 Georgia Ave. | | | | 10f. ZIP CODE 20902 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) 12 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SECRETARY | | 16b. KIND OF BUSINESS/INDUSTRY US GOVERNMENT | | | |
| 17. FATHER'S NAME (First, Middle, Last) Meyer Kalmans | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Gilbert | | | |
| 19a. INFORMANT'S NAME (Type/Print) Irving Cohn | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Hopkins Plaza, Baltimore, MD. 21201-2914 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Chesed Shel Emmes Cem. 7-31-97 | | 20c. LOCATION — City or Town, State Washington DC | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Danzansky-Goldberg Mem. Chapel, Inc 1170 Rockville Pike, Rockville, MD. 20852 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Dementia | | | | | | | |
| a. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. Schizophrenia | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ascites | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER D 43237 | | 29d. DATE SIGNED (Month, Day, Year) July 29, 1997 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Paul Armstrong, MD, 14201 Laurel Park Dr., Laurel, MD. 20707 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) AUG 5 1997 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25051

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Lawrence Alexander Keefer

2. Date of Death

August 1, 1997

3. Time of Death

5:30 AM

4a. Facility Name (If not institution, give street and number)

2816 Perego Drive

4b. City, Town, or Location of Death

Kensington

4c. County of Death

Montgomery

5. Social Security Number

578-18-5574

6. Sex

155 M 20 F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Oct. 31, 1919

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Kensington

10d. Inside City Limits

10 Yes 20 No

10e. Street and Number

2816 Perego Drive

10f. Zip Code

20895

10g. Citizen of What Country?

U.S.A.

11. Marital Status

10 Never Married 20 Married
30 Widowed 40 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

10 Yes 20 No

If Yes, Give

Year or Dates: 1950-1952

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10 Yes 20 No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Engineer

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

William Alexander Keefer

18. Mother's Name (First, Middle, Maiden Surname)

Esther May Dreibelbis

19a. Informant's Name/Relationship (Type, Print)

Ivalee B. Keefer

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2816 Perego Drive Kensington, Maryland 20895

20a. Method of Disposition

10 Burial 20 Cremation 30 Removal from State
40 Donation 50 Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metropolitan Crematory

Date

8/02/97

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

e. Metastatic Carcinoma

5 Months

Due to (or as a consequence of):

b. Lung Cancer

10 Months

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy
performed?

10 Yes 20 No

24b. Were autopsy findings
available prior to
completion of cause
of death?

10 Yes 20 No

25. Was case referred to medical
examiner?

10 Yes 20 No

Hospital:

10 Inpatient 20 ER/Outpatient 30 DOA

26. Place of Death (Check only one)

Other: 40 Nursing Home 50 Residence 80 Other (Specify)

27. Manner of Death

10 Natural 50 Pending
20 Accident investigation
30 Suicide 60 Could not be
40 Homicide determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

10 Yes 20 No

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)20 Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 09470

29d. Date signed (Month, Day, Year)

August 1, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eugene P. Libre, M.D. 10400 Connecticut Avenue Kensington, Maryland 20885

31. Date filed (Month, Day, Year)

AUG 4 1997

32. Registrar's Signature

John Davidson-Rendall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 25052

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Cheol Mo Kim

2. Date of Death

August 3, 1997

3. Time of Death

6:00 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

440 University Boulevard, East #201

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

213-27-1694

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

April 4, 1923

9. Birthplace (State or Foreign Country)

Korea

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

440 University Boulevard, East #201

10f. Zip Code

20901

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
Asian15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

3

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Owner

16b. Kind of Business/Industry

Dry Cleaning Shop

17. Father's Name (First, Middle, Last)

Unknown Kim

18. Mother's Name (First, Middle, Maiden Surname)

Unknown

19a. Informant's Name/Relationship (Type, Print)

Doo Eun Kim

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

440 University Blvd., East #201 Silver Spring, MD 20901

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metropolitan Crematory

Date

8/5/97 Alexandria, Virginia

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

William L. Byrd

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Ischemic Heart Disease

Due to (or as a consequence of):

10yrs.

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Renal Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of Certifier

Stephen Hellman, M.D.

29c. License number

D 20674

29d. Date signed (Month, Day, Year)

August 4, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen Hellman, M.D. 6240 Montrose Road Rockville, Maryland 20852

31. Date filed (Month, Day, Year)

August 5, 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State of Maryland / Department of Health and Mental Hygiene 97 25053
Certificate of Death Reg. No.

Reg. No.

DHHM 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25054

Amended #6, 8/14/97, GF, Montg.Co.

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Anna Mae Knupp

2. Date of Death

August 4, 1997

3. Time of Death

3:05P.

4a. Facility Name (If not institution, give street and number)

Laurel Regional Hospital

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

186-30-7557

6. Sex

-XXM- 2XXF

7. Age (In yrs. last birthday)

58 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 27, 1938

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1X Yes 2X No

10e. Street and Number

3410 Dogwood Drive

10f. Zip Code

21042

10g. Citizen of What Country?

United States

11. Marital Status

1X Never Married 2X Married
3X Widowed 4XX Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1X Yes XX No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1X Yes XX No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Data Processing

16b. Kind of Business/Industry

District Photo

17. Father's Name (First, Middle, Last)

Walter G. Martz

18. Mother's Name (First, Middle, Maiden Surname)

Flora Mercurio

19a. Informant's Name/Relationship (Type, Print)

Judy Berti (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4035 Howes Court Dunkirk, Maryland 20754

20a. Method of Disposition

1X Burial 2XX Cremation 3X Removal from State
4X Donation 5X Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metropolitan Crematory 8/6/1997 Alexandria, Virginia

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Donald V. Borgwardt

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, P.A.
4400 Powder Mill Rd. Beltsville, Maryland 2070523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Alcoholic Cirrhosis with sepsis

Approximate
Interval Between
Onset and Death

2 weeks

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1X Yes 2X No 3X Probably 4X Unknown

24a. Was an autopsy
performed?

1X Yes 2X No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1X Yes 2X No

25. Was case referred to medical
examiner?

1X Yes 2X No

Hospital:

1X Inpatient

2X ER/Outpatient

3X DOA

Other:

4X Nursing Home

5X Residence

6X Other (Specify)

27. Manner of Death

1X Natural 5X Pending
2X Accident investigation
3X Suicide 6X Could not be
4X Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?

1X Yes 2X No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Richard Chasen, M.D.

29c. License number

D22862

29d. Date signed (Month, Day, Year)

Aug. 5, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Richard Chasen, M.D. 7350 Van Dusen Rd., #230 Laurel, Maryland 20707

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25055
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

IBATTA

KONNEH

2. Date of Death

Month Day Year

Aug 4 1997

3. Time of Death

5:55

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

5. Social Security Number

220-33-5424

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) Oct. 25, 1923

9. Birthplace (State or Foreign Country)

Sierra Leone

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Olney

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

27 Shadow Ridge Court

10f. Zip Code

20832

10g. Citizen of What Country?

Sierra Leone, West Africa

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

N/A

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Uamba Konneh

18. Mother's Name (First, Middle, Maiden Surname)

Hawa Kamara

19a. Informant's Name/Relationship (Type, Print)

Abdul Ishiaka Magona / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

27 Shadow Ridge Court, Olney, Maryland 20832

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

George Washington Cem.

Date

8/15/97

20c. Location - City or Town, State

Adelphi, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hines-Rinaldi Funeral Home

11800 New Hampshire Avenue

Silver Spring, Maryland 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Septic

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

24 hrs.

b.

Peritonitis

Due to (or as a consequence of):

48 hrs.

c.

Pneumonia

Due to (or as a consequence of):

48 hrs.

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D08546

29d. Date signed (Month, Day, Year)

Aug 4 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Tauber

8218 Wisconsin Ave Bethesda

31. Date filed (Month, Day, Year)

AUG 08 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25056

Item:23b per MD G-750 8/26/97 dh

Certificate of Death

Reg. No.

| | | | | | | | | | | | | |
|--|--|---------------------------------------|---|--|--|--|--|--------------------------------------|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Richard Kenneth Ladd | | | | 2. Date of Death Month Day Year August 2, 1997 | | | | 3. Time of Death 7:04 AM | | | |
| | 4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital | | | | 4b. City, Town, or Location of Death Rockville | | | | 4c. County of Death Montgomery | | | |
| Funeral Director | 5. Social Security Number 215-38-7340 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (in yrs. last birthday) 55 Yrs. | | 8. Date of Birth (Month, Day, Year) Nov. 29, 1941 | | 9. Birthplace (State or Foreign Country) Washington, D.C. | | | |
| | Usual Residence of Decedent | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Germantown | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | 10e. Street and Number 23129 Bank Barn Court | | | | 10f. Zip Code 20876 | | | | 10g. Citizen of What Country? United States | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1960-66 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Salesperson | | | | 16b. Kind of Business/Industry Plumbing | | | |
| | 17. Father's Name (First, Middle, Last) Herman Camp Ladd | | | | 18. Mother's Name (First, Middle, Maiden Surname) Viola Thompson | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Shirley L. Ladd/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23129 Bank Barn Court, Germantown, Maryland 20876 | | | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Norbeck Memorial Park | | Date August 5, 1997 | | 20c. Location - City or Town, State Olney, Maryland | | | | | |
| | 21. Signature of Funeral Service Licensee <i>Michael P. Kutta</i> M00348 | | | | 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Acute myocardial infarction</i> Due to (or as a consequence of): b. <i>Adenocarcinoma unknown primary</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death <i>MINUTES</i> <i>ONE YEAR</i> | | | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> No 2 <input type="checkbox"/> Yes 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier <i>M.O.</i> | | | | 29c. License number <i>D37024</i> | | | | |
| 29d. Date signed (Month, Day, Year) <i>AUGUST 2, 1997</i> | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>DAVID SROUR 9901 Medical Center Drive Rockville, Md. 20850</i> | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) <i>AUG 4 1997</i> | | | | 32. Registrar's Signature <i>Julia Davidson-Randall</i> | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25057

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|---|--------------------------------|--|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) THOMAS J. LEE | | | | 2. Date of Death Month July Day 30 Year 1997 | | 3. Time of Death 6:10 P.M. | |
| | 4a. Facility Name (If not institution, give street and number) Brooke Grove Nursing Center | | | | 4b. City, Town, or Location of Death Sandy Spring | | 4c. County of Death MONTGOMERY | |
| Funeral Director | 5. Social Security Number 214-32-9063 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 71 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) May 30, 1926 | | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | 10b. County Montgomery | 10c. City, Town or Location Sandy Spring | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10a. Street and Number 17519 Norwood Road | | | 10f. Zip Code 20860 | | 10g. Citizen of What Country? U.S.A. | | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dish Washer | | 16b. Kind of Business/Industry Food Service | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) John W. Lee | | | | 18. Mother's Name (First, Middle, Maiden Surname) Daisy P. Walker | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Clifton Lee (Nephew) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18556 Brooke Rd., Sandy Spring, MD 20860 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Ash Memorial Cem. | | 20c. Location - City or Town, State 8/5/97 Sandy Spring, MD | | 20d. Date | |
| | 21. Signature of Funeral Service Licensee <i>George R. Snowden</i> | | 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850 | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. LUNG CANCER WITH CEREBRAL METASTASES Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | Approximate Interval Between Onset and Death 6 MONTHS |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | 28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| | 29b. Signature and title of certifier <i>T. E. Howe</i> MD | | 29c. License number D33700 | | 29d. Date signed (Month, Day, Year) July 31, 1997 | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Ted E. Howe, M.D. 7542 Overlook Dr. Boonsboro, MD 21713 | | | | | | | |
| | 31. Date filed (Month, Day, Year) AUG 4 1997 | | 32. Registrar's Signature <i>John Davidson-Randall</i> | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25058

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>James R. Loftis Jr.</u> | | | | 2. Date of Death Month <u>Aug</u> Day <u>5</u> Year <u>1997</u> | | 3. Time of Death <u>3:45 pm</u> | |
| | 4a. Facility Name (If not institution, give street and number) <u>Manor Care-Bethesda</u> | | | | 4b. City, Town, or Location of Death <u>Chevy Chase</u> | | 4c. County of Death <u>Montgomery</u> | |
| Funeral Director | 5. Social Security Number <u>216.44.4456</u> | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) <u>85</u> Yrs. | | 8. Date of Birth (Month, Day, Year) <u>March 10, 1912</u> | |
| | 9. Birthplace (State or Foreign Country) <u>Utah</u> | | 10. Usual Residence of Decedent 10a. State <u>Maryland</u> 10b. County <u>Montgomery</u> 10c. City, Town or Location <u>Bethesda</u> 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 11. Street and Number <u>8307 Thoreau Drive</u> | | 12. Zip Code <u>20817</u> | |
| To Be Completed by Funeral Director | 13. Marital Status 1 <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 14. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: <u>Army WWII</u> | | 15. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: _____ | | 16. Race - American Indian, Black, White, etc. Specify: <u>White</u> | |
| | 17. Decedent's Education (Specify only highest grade completed) <u>Elementary/Secondary (0-12)</u> | | 18. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Assistant to the Secretary of Defense for Administration</u> | | 19. Kind of Business/Industry <u>U.S. Government</u> | | 20. Father's Name (First, Middle, Last) <u>James R. Loftis, Sr.</u> | |
| To Be Completed by Physician/Medical Examiner | 21. Mother's Name (First, Middle, Maiden Surname) <u>Clara Easterbrooks</u> | | 22. Informant's Name/Relationship (Type, Print) <u>James R. Loftis, III/ Son</u> | | 23. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>4124 North Round Hill Road Arlington, Va. 22207</u> | | 24. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) _____ | |
| | 25. Place of Disposition (Name of cemetery, crematory or other place) <u>Mt. Comfort Crematory</u> | | 26. Date <u>8/11/97</u> | | 27. Location - City or Town, State <u>Alexandria, Va.</u> | | 28. Signature of Funeral Service Licensee <u>John M. Peters</u> | |
| Physician /Medical Examiner | 29. Name and Address of Facility <u>Joseph Gawler's Sons, Inc.</u> | | 30. 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <u>metastatic carcinoma of the prostate</u> | | 31. Approximate Interval Between Onset and Death <u>years</u> | | 32. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | |
| | 33. 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 34. 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 35. 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 36. 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | 37. 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) _____ | | 38. 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 39. 28a. Date of Injury (Month, Day, Year) <u>Aug 10 1997</u> | | 40. 28b. Time of Injury <u>M</u> | |
| | 41. 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 42. 28d. Describe how injury occurred | | 43. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 44. 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | 45. 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 46. 29b. Signature and title of certifier <u>John Tauber</u> | | 47. 29c. License number <u>D08546</u> | | 48. 29d. Date signed (Month, Day, Year) <u>Aug 5, 1997</u> | |
| | 49. 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <u>John Tauber 8718 Wisconsin Ave Bethesda MD</u> | | 50. 31. Date filed (Month, Day, Year) <u>AUG 08 1997</u> | | 51. 32. Registrar's Signature <u>John Davidson-Randall</u> | | 52. State Registrar | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25059

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

PAUL

RIPPERE

LAFRANCE

2. Date of Death

August 01 1997

Day Year

3. Time of Death

1059

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral
Director

5. Social Security Number

116-26-6029

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

62 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

October 19, 1934

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

603 Ardmore Terrace

10f. Zip Code

21804

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

3 1/2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Engineer/manager

16b. Kind of Business/Industry

Manufacturing

17. Father's Name (First, Middle, Last)

Paul Rippere LaFrance Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Gladys Vivian Griswold

19a. Informant's Name/Relationship (Type, Print)

Marilyn S. LaFrance/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

603 Ardmore Terrace, Salisbury, MD 21804

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Wicomico Memorial Park

Date

8/6/97

20c. Location - City or Town, State

Salisbury, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Holloway Funeral Home

501 Snow Hill Rd., Salisbury, MD 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

shock, or heart failure. List only one cause on each line.

Immediate Cause (Final

disease or condition

resulting in death)

Colon Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

3 mos.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Severe Coagulopathy

Gram Negative Sepsis

Severe Anemia

Coronary Artery Disease

Atrial Fibrillation

Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

044069

29d. Date signed (Month, Day, Year)

8-1-97

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

JOSEPH ANDERSON, MD 106 MILLERS ST #106

SALISBURY, MD 21804

31. Date filed (Month, Day, Year)

AUG 05 1997

32. Registrar's Signature

State
Registrar

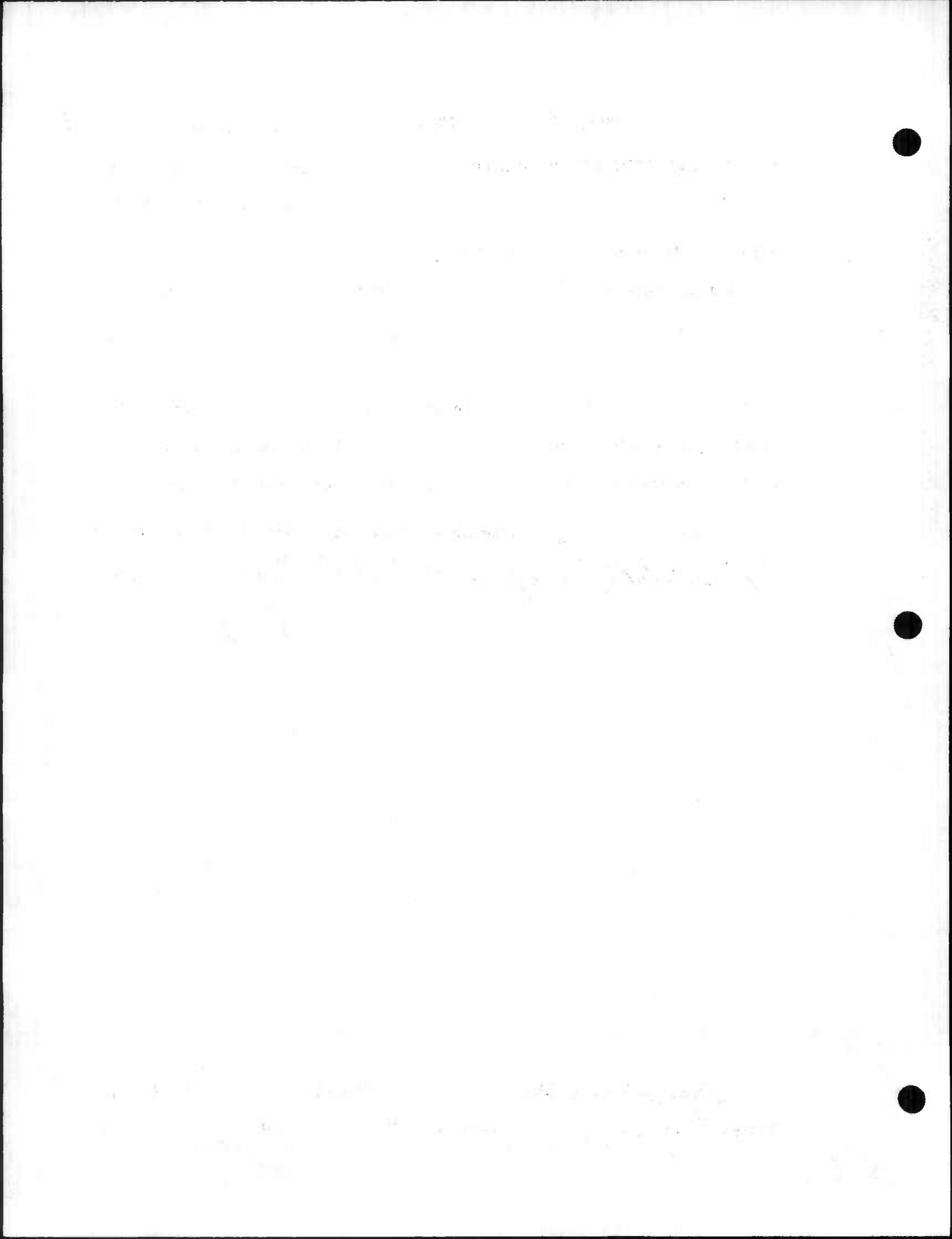
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



97 25060

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Marlin Luther LeGore | | | | 2. DATE OF DEATH MONTH DAY YEAR August 2 1997 | | 3. TIME OF DEATH 1:21PM M | |
| 4. SOCIAL SECURITY NUMBER 213-10-2091 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 87 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Sept. 7, 1909 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) 9625 Old Hoffman Seachrist Rd. | | 9b. CITY, TOWN OR LOCATION OF DEATH Walkersville | |
| 9c. COUNTY OF DEATH Frederick | | | | 10a. STATE Maryland | | | |
| 10b. COUNTY Frederick | | 10c. CITY, TOWN OR LOCATION Walkersville | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 9625 Old Hoffman Seachrist Rd. | |
| 10f. ZIP CODE 21793 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1944-1946 | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 5+) 2 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) management | |
| 16b. KIND OF BUSINESS/INDUSTRY lime company | | 17. FATHER'S NAME (First, Middle, Last) Walter LeGore | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Bertha Smith | | 19a. INFORMANT'S NAME (Type/Print) Rondel K. LeGore/ son | |
| 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21793 9625 Old Hoffman Seachrist Rd. Walkersville, MD | | 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Hope Cemetery 8/6 | | 20c. LOCATION — City or Town, State Woodsboro, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Catharine D. Hartzler</i> | | 22. NAME AND ADDRESS OF FACILITY Hartzler Funeral Home Woodsboro, MD | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Hypothyroidism</u> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval between Onset and Death Years | | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Andrew Zarick, Jr.</i> | | 29c. LICENSE NUMBER D35164 | | 29d. DATE SIGNED (Month, Day, Year) 8/3/97 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Andrew Zarick, Jr. 1080 W. Patrick St. Frederick, MD 21703 | | 31. DATE FILED (Month, Day, Year) AUG 06 1997 | | 32. REGISTRAR'S SIGNATURE <i>Juba Davidson Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25061

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LEON MARTYSZ, JR.

2. Date of Death

Month Day Year
AUGUST 4, 1997

3. Time of Death

10:00 AM

4a. Facility Name (If not institution, give street and number)

7312 OLIVE TREE COURT

4b. City, Town, or Location of Death

GAITHERSBURG

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

370-52-8749

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

48

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
MAR 28, 1949

9. Birthplace (State or Foreign Country)

MICHIGAN

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

GAITHERSBURG

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7312 OLIVE TREE COURT

10f. Zip Code

20879

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

FINANCIAL MANAGER

16b. Kind of Business/Industry

POWER INDUSTRY

17. Father's Name (First, Middle, Last)

LEON MARTYSZ, SR.

18. Mother's Name (First, Middle, Maiden Surname)

MARY CHIMBAR

19a. Informant's Name/Relationship (Type, Print)

PRISCILLA C. MARTYSZ, WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7312 OLIVE TREE COURT, GAITHERSBURG, MD 20879

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

METROPOLITAN CREMATORY

Date

AUG. 5, 1997

20c. Location - City or Town, State

ALEXANDRIA, VIRGINIA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DEVOL FUNERAL HOME

10 EAST DEER PARK DR., GAITHERSBURG, MD 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. respiratory failure

4 months

Due to (or as a consequence of):

b. Hodgkin's Disease

3 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Henry B Fox, M.D.

29c. License number

18126

29d. Date signed (Month, Day, Year)

AUGUST 5, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HENRY FOX, M.D., 2440 "M" STREET, NW #606 WASHINGTON, D.C. 20037

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit document and retained by the funeral director.
*CLEARED & RELEASED BY DR. TAUBER, MEDICAL EXAMINER

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25062

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WARRENA VARNER MASON

2. Date of Death

August 1 1997

Day Year

3. Time of Death

12 noon

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

302-10-0303

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

July 12, 1915

9. Birthplace (State or Foreign Country)

Alabama

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

514 Hillsboro Drive

10f. Zip Code

20902

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

4 College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Accountant

16b. Kind of Business/Industry

Banking

17. Father's Name (First, Middle, Last)

Hayes Varner

18. Mother's Name (First, Middle, Maiden Surname)

Emma Bryant

19a. Informant's Name/Relationship (Type, Print)

Sylvia Lewis (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

514 Hillsboro Dr. Silver Spring, MD 20902

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

West Memory Gardens

Date

8-6-97

20c. Location - City or Town, State

Dayton, Ohio

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hines Rinaldi Funeral Home 11800

New Hampshire Ave. Silver Spring, MD 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

METASTATIC lung cancer

Due to (or as a consequence of)

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

10 mos

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ESOPHOGEAL OBSTRUCTION

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D29675

29d. Date signed (Month, Day, Year)

Aug 1 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RALPH V. BOCCIA MD

9707 MEDICAL CENTER DR. #300 ROCKVILLE

31. Date filed (Month, Day, Year)

AUG 5 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25063

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Charlotte E. McCarthy

2. Date of Death

Month

Day

Year

August 1, 1997

3. Time of Death

8:45 PM

4a. Facility Name (If not institution, give street and number)

Genesis ElderCare - Layhill Center

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

577-12-7587

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Aug. 11, 1919

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13315 Foxhall Drive

10f. Zip Code

20906

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

United Way

17. Father's Name (First, Middle, Last)

John McCarthy

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Quigley

19a. Informant's Name/Relationship (Type, Print)

Bernard Bethke

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13315 Foxhall Drive Silver Spring, Maryland 20906

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

8/4/97

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Aug 1, 1997

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimers

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Wilkinson J. Ninala

29c. License number

D45285

29d. Date signed (Month, Day, Year)

August 3, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Wilkinson J. Ninala, M.D. 18111 Prince Phillip Drive #212 Olney, Maryland 20832

31. Date filed (Month, Day, Year)

AUG 4 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25064

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ruth C. McDyer

2. Date of Death

Month Day Year
August 5, 1997

3. Time of Death

1:50 PM

4a. Facility Name (If not institution, give street and number)

Springbrook Adventist Nursing

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

147-22-3460

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb. 21, 1910

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12407 Eastbourne Drive

10f. Zip Code

20904-2038

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

18a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Floyd R. Young

18. Mother's Name (First, Middle, Maiden Surname)

Mary L. Murphy

19a. Informant's Name/Relationship (Type, Print)

Mary C. McDyer

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12407 Eastbourne Drive Silver Spring, Maryland 20904-2038

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metropolitan Crematory

Date

8/9/97 Alexandria, Virginia

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Stern D Stern

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METABOLIC ENCEPHALOPATHY

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

few weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

M-S Mayer

29c. License number

D-17874

29d. Date signed (Month, Day, Year)

8-5-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

S. M. NAYAR, MD, 3717 - 38th Ave BRENTWOOD, MD 20722

31. Date filed (Month, Day, Year)

AUG 08 1997

32. Registrar's Signature

John Davidson-Rodriguez

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25065

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ERNIE L. McFARLANE

2. Date of Death

Month Day Year
AUGUST 2, 1997

3. Time of Death

2:17 am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

PRINCE GEORGE COMMUNITY HOSPITAL

4b. City, Town, or Location of Death

CHEVERLY

4c. County of Death

PRINCE GEORGE

5. Social Security Number

218-19-8107

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 3, 1932

9. Birthplace (State or Foreign Country)

Jamaica, WI

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

14412 Taos Court

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Private Industry

17. Father's Name (First, Middle, Last)

George Pencle

18. Mother's Name (First, Middle, Maiden Summa)

Eugina Howlett

19a. Informant's Name/Relationship (Type, Print)

Marie McFarlane - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14412 Taos Court, Silver Spring, MD 20906

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Gate of Heaven Cem.

Date

8/9/97

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

R. N. Horton Co. Morticians, Inc.
600 Kennedy Street, NW, DC 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Intracranial hemorrhage.

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

7-days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D-34525

29d. Date signed (Month, Day, Year)

08-02-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. J. Rao, MD; 4000-Mitchellville Road; #220; Bowie-MD-20716

31. Date filed (Month, Day, Year)

AUG 4 1997

32. Registrar's Signature

State
RegistrarERNIE McFARLANE 8-2-97-2:17 A.M.
BowieDivision of Vital Records, P.O. Box 68760,
Baltimore, Maryland 21215-0020To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25066

| | | | | | | | | |
|---|---|--|---|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ROBERT GERARD MELLON | | | | 2. Date of Death Month Day Year AUG 01 1997 | | 3. Time of Death 1356 (pm) | |
| | 4a. Facility Name (If not institution, give street and number) NATIONAL NAVAL MEDICAL CENTER BETHESDA | | | | 4b. City, Town, or Location of Death BETHESDA | | 4c. County of Death MONTGOMERY CO | |
| Funeral Director | 5. Social Security Number 034-36-9325 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 48 Yrs. | | 8. Date of Birth (Month, Day, Year) January 28, 1949 | |
| | 9. Birthplace (State or Foreign Country) Massachusetts | | 10. Usual Residence of Decedent 10a. State North Carolina 10b. County Onslow 10c. City, Town or Location Jacksonville 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1970-1997 | |
| To Be Completed by Funeral Director | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Officer | |
| | 16b. Kind of Business/Industry United States Marine Corps | | 17. Father's Name (First, Middle, Last) Robert James Mellon | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Elizabeth Kennedy | | 19a. Informant's Name/Relationship (Type, Print) Barbara A. Mellon/Wife | |
| Physician /Medical Examiner | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 916 Eton Drive, Jacksonville, North Carolina 28546 | | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cemetery August 6, 1997 | | 20c. Location - City or Town, State Arlington, Virginia | |
| | 21. Signature of Funeral Service Licensee Michael E. Higgins M00846 | | 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. LIVER FAILURE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death | |
| Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier J. L. CROOK, LT, MC, USN | | 29c. License number RES-000 | | 29d. Date signed (Month, Day, Year) 01 AUG 1997 | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. L. CROOK, LT, MC, USN. NATNAVMEDCEN BETHESDA, MD 20889-5000 | | | | | | | |
| | 31. Date filed (Month, Day, Year) AUG 04 1997 | | | | 32. Registrar's Signature John Davidson-Rendall | | | |

97 25067

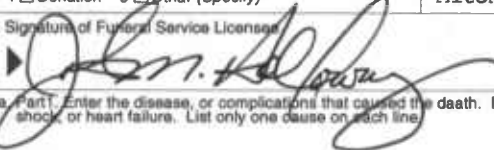
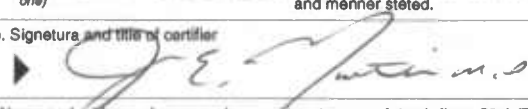

DHHH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25068

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|--|---|---|--|--|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JUNE ELIZABETH MITCHELL | | | | 2. Date of Death Month Day Year July 31, 1997 | | 3. Time of Death 8:35 AM | | |
| | 4a. Facility Name (If not institution, give street and number) 4072 Snow Hill Road | | | | 4b. City, Town, or Location of Death Salisbury | | 4c. County of Death Wicomico | | |
| Funeral Director | 5. Social Security Number 218-20-8561 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 67 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) January 15, 1930 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | 10b. County Wicomico | | 10c. City, Town or Location Salisbury | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number 4072 Snow Hill Road | | | 10f. Zip Code 21804 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 1/2 Collage (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | 16b. Kind of Business/Industry Domestic | | | |
| | 17. Father's Name (First, Middle, Last) Joseph E. Pope | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary E. Green | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Quentin E. Mitchell/son | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4072 Snow Hill Rd., Salisbury, MD 21804 | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mitchell Family Cemetery | | Data 8/4/97 | | 20c. Location - City or Town, State Salisbury, MD | | |
| | 21. Signature of Funeral Service Licensee  | | | 22. Name and Address of Facility Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21804 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Carcinoma of Colon</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death 1 year |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and Title of certifier  | | 29c. License number 030690 | | 29d. Date signed (Month, Day, Year) Aug. 1, 1997 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James E. Martin, M.D., 145 E. Carroll St., Salisbury, MD. | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 04 1997 | | 32. Registrar's Signature  | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25069

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|---|---|---|---|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Roland David Mason | | | | 2. Date of Death Month August Day 1 Year 1997 | | 3. Time of Death 10:15 A.M. | | |
| | 4a. Facility Name (If not institution, give street and number) Waterview Healthcare Center | | | | 4b. City, Town, or Location of Death Salisbury | | 4c. County of Death Wicomico | | |
| Funeral Director | 5. Social Security Number 221-10-1541 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 86 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Oct. 30, 1910 | | 9. Birthplace (State or Foreign Country) Virginia | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | 10b. County Wicomico | | 10c. City, Town or Location Salisbury | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number 105 Times Square | | | 10f. Zip Code 21801 | | 10g. Citizen of What Country? U.S.A. | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Army If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer | | | 16b. Kind of Business/Industry Construction | | |
| | 17. Father's Name (First, Middle, Last) Charles B. Mason | | | | 18. Mother's Name (First, Middle, Maiden Surname) Bertha Bell Hayman | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Susan M. Johnson - Niece | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 819 Riverside Dr. Salisbury, MD 21801 | | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Cambridge Crematory | | Date 8-2-97 | | 20c. Location - City or Town, State Cambridge, MD | | |
| | 21. Signature of Funeral Service Licensee B. Keith Phipps, CFSP | | | | 22. Name and Address of Facility 705 E. Main St. Bounds Funeral Home Salisbury, MD 21804 | | | | |
| | 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Congestive Heart Failure Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d. | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Sick sinus syndrome CVA | | | | | | 24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Makesh Moudra MD | | 29c. License number D32014 | | 29d. Date signed (Month, Day, Year) 8/19/97 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MAKESH MOUDRA MD 106 WILFORD STREET SUITE 505B SALISBURY MD 21804 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 04 1997 | | 32. Registrar's Signature John Anderson Randall | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25070

| | | | | | | | | | |
|---|---|--------------------------------|--|---|---|---|--|---|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>Curtis MELSON</i> | | | | | 2. Date of Death Month <i>AUGUST</i> Day <i>10</i> Year <i>1997</i> | | 3. Time of Death <i>1:10 AM</i> | |
| | 4a. Facility Name (If not institution, give street and number) <i>SHORE NURSING & REHABILITATION CTR.</i> | | | | | 4b. City, Town, or Location of Death <i>DENTON</i> | | 4c. County of Death <i>CAROLINE</i> | |
| Funeral Director | 5. Social Security Number <i>238-20-89988</i> | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) <i>73</i> Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) <i>1-1-24</i> | | 9. Birthplace (State or Foreign Country) <i>NC</i> |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State <i>MD</i> | 10b. County <i>Caroline</i> | | 10c. City, Town or Location <i>Denton</i> | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number <i>208 N. 4th Street</i> | | | | 10f. Zip Code <i>21629</i> | | 10g. Citizen of What Country? <i>USA</i> | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <i>4/10/45</i> | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <i>Black</i> | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Chauffeur</i> | | | 16b. Kind of Business/Industry <i>Self-Employed</i> | | |
| | 17. Father's Name (First, Middle, Last) <i>Nathaniel Carter</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <i>Laura Melson</i> | | | | |
| Physician /Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) <i>Sandra Purkett</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2815 Leisure Woods Lane Decatur GA 30034</i> | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Veteran's Cemetery</i> | | Date <i>8-13-97</i> | 20c. Location - City or Town, State <i>Hurlock, Md</i> | | | |
| | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility <i>Lewis & Watkins Funeral Home 1618 West Rd Salisbury Md 21801</i> | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>GASTRIC ADENOCARCINOMA</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury <i>M</i> | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier <i>[Signature] MD</i> | | | | | 29c. License number <i>D35284</i> | | 29d. Date signed (Month, Day, Year) <i>8/11/97</i> | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>ANDREA ACORN MD 920 Market St Denton MD 21629</i> | | | | | | | | | |
| 31. Date filed (Month, Day, Year) <i>AUG 12 '97</i> | | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25071

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Priscilla Lynn McNally-Barge

2. Date of Death

Month Day Year
August 3, 1997

3. Time of Death

5:05 P.M.

4a. Facility Name (If not Institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

Baltimore City

5. Social Security Number

unknown

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

0 Yrs.

If Under 1 Year

Months Days

0 11

If Under 24 Hrs.

Hours Min.

0 0

8. Date of Birth (Month, Day, Year)

July 24, 1997

9. Birthplace (State or Foreign Country)

Baltimore, Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

Carroll County

10c. City, Town or Location

Hampstead

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

P.O. Box 692 Main Street

10f. Zip Code

21074

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

none

College (1-4 or 5+)

none

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

none

16b. Kind of Business/Industry

none

17. Father's Name (First, Middle, Last)

Morgan Barge

18. Mother's Name (First, Middle, Maiden Surname)

Michele A. McNally

19a. Informant's Name/Relationship (Type, Print)

Michele McNally/mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 692, Hampstead, Md. 21074

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

8/5/97

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Briem L. Haight

22. Name and Address of Facility

Haight Funeral Home & Chapel (Box 195)
Sykesville, MD 21784 (410) 795-1400

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Trisomy 18

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

11 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Esophageal atresia

Tracheoesophageal fistula

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Kathleen L. McDonald

29c. License number

D-47766

29d. Date signed (Month, Day, Year)

8/3/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kathleen L. McDonald, M.D. Sinai Hospital 2401 W. Belvedere Ave. Balto, Md. 21215

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

John Davidson Randall

State
Registrar

Girl McNally

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25072
Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|--|---|--|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Thomas J. McGinnis | | | | | | 2. Date of Death Month Day Year August 7, 1997 | | 3. Time of Death 6:35 a.m. | |
| | 4a. Facility Name (If not institution, give street and number) 224 Broad Street (At Home) | | | | | | 4b. City, Town, or Location of Death Crumpton | | 4c. County of Death Queen Annes | |
| Funeral Director | 5. Social Security Number 215-36-2138 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 95 Yrs. | | 8. Date of Birth (Month, Day, Year) October 27, 1901 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Queen Annes | | 10c. City, Town or Location Crumpton | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 10e. Street and Number 224 Broad Street | | | | 10f. Zip Code 21628 | | 10g. Citizen of What Country? U.S.A. | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farmer | | | 16b. Kind of Business/Industry Agricultural | | |
| | 17. Father's Name (First, Middle, Last) Lemuel G. McGinnis | | | | 18. Mother's Name (First, Middle, Maiden Surname) Clara Hoffecker | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Howard Johnson/Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 7, Crumpton, Maryland 21628 | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Crumpton Cemetery/August | | | | 20c. Location - City or Town, State Crumpton, Maryland | | | |
| | 21. Signature of Funeral Service Licensee <i>Gay B. Sullivan</i> | | | | 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | |
| | 23b. Approximate Interval Between Onset and Death 24 hrs | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Immediate Cause (Final disease or condition resulting in death) a. Cardio Respiratory Failure Due to (or as a consequence of): b. Arterio Sclerotic Cardio Vascular Dz Due to (or as a consequence of): c. Due to (or as a consequence of): d. { Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD/Hyperlipidemia/HxTIA/Peripheral Vascular Dz/Cerebrovascular Dz/HTN OA | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| | 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| State Registrar | 29b. Signature and title of certifier <i>Neil Stoddard</i> | | | | 29c. License number D005099C | | 29d. Date signed (Month, Day, Year) 8/11/97 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Neil Stoddard, M.D. 100 Brown Street Chester town, Md. | | | | | | | | | |
| | 31. Date filed (Month, Day, Year) Aug. 11, 1997 | | | | 32. Registrar's Signature <i>Julia Davidson-Randall</i> | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

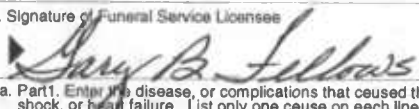
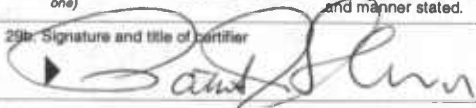
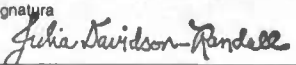
6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25073

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|---|---|---|--|---|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Walter Wayne McGuire | | | | 2. Date of Death Month: 07 Day: 26 Year: 1997 | | 3. Time of Death 2219 PM | |
| | 4a. Facility Name (If not institution, give street and number) Kent & Queen Anne's Hospital, Inc. | | | | 4b. City, Town, or Location of Death Chestertown | | 4c. County of Death Kent | |
| Funeral Director | 5. Social Security Number 152-22-4604 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 82 Yrs. | If Under 1 Year Months: Days: | If Under 24 Hrs. Hours: Min. | 8. Date of Birth (Month, Day, Year) May 5, 1915 | | 9. Birthplace (State or Foreign Country) New Jersey |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | 10b. County Kent | 10c. City, Town or Location Chestertown | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number 1006 Twin Court | | | 10f. Zip Code 21620 | | 10g. Citizen of What Country? U.S.A. | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (1-4 or 5+): 2 | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Automobile Salesman | | 16b. Kind of Business/Industry Automotive | | |
| | 17. Father's Name (First, Middle, Last) John A. McGuire | | | | 18. Mother's Name (First, Middle, Maiden Surname) Grace F. (Unknown) McGuire | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Ruth E. McGuire/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1006 Twin Court, Chestertown, Maryland 21620 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Christ I.U. Cemetery/July 30, 1997 Worton, Maryland | | Date | | 20c. Location - City or Town, State | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CONGESTIVE HEART FAILURE Due to (or as a consequence of): D.M. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) N/A | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred N/A |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number D 36054 | | 29d. Date signed (Month, Day, Year) July 28, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Patrick Shanahan, MD, Speer Road, Chestertown, Maryland 21620 | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 29 '97 | | 32. Registrar's Signature  | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

6

State
Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25074

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Spiridoula

Niforos

2. Date of Death

Month Day Year
August 04, 1997

3. Time of Death

1:45PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Fairland Adventist Nursing

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

334-50-4576

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sep. 15, 1911

9. Birthplace (State or Foreign Country)

Greece

Usual Residence of Decedent

10e. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Brookeville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2921 Vandever Street

10f. Zip Code

20833

10g. Citizen of What Country?

Greece

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:
White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
9

College (1-4 or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Panagiotis Glikis

18. Mother's Name (First, Middle, Maiden Surname)

Vasiliki Unknown

19a. Informant's Name/Relationship (Type, Print)

Peggy Maroulis

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9664 Fleetwood Court Frederick, Maryland 21701

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

Data

8/7/97

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

WEEKS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CEREBROVASCULAR ACCIDENT

ORGANIC BRAIN SYNDROME

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ OOA

Other:

28. Place of Death (Check only one)

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D24997

29d. Date signed (Month, Day, Year)

8/4/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LUIS A. CASAS MD 8317 CHERMAY LANE LAUREL MD 20707

31. Date filed (Month, Day, Year)

AUG 07 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. The first part of the report deals with the general situation of the country and the progress of the work during the year. It also mentions the results of the various investigations and the conclusions drawn from them.

2. The second part of the report deals with the results of the various investigations and the conclusions drawn from them. It also mentions the progress of the work during the year.

3. The third part of the report deals with the results of the various investigations and the conclusions drawn from them. It also mentions the progress of the work during the year. The fourth part of the report deals with the results of the various investigations and the conclusions drawn from them. It also mentions the progress of the work during the year.

4. The fifth part of the report deals with the results of the various investigations and the conclusions drawn from them. It also mentions the progress of the work during the year.

5. The sixth part of the report deals with the results of the various investigations and the conclusions drawn from them. It also mentions the progress of the work during the year.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25075

Certificate of Death

Reg. No.

| | | | | | |
|-------------------------------------|---|--|---|---------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Edmund Anthony Nowlin | | 2. Date of Death Month July Day 30 , Year 1997 | | 3. Time of Death 8:32 PM |
| | 4a. Facility Name (If not Institution, give street and number) Suburban Hospital | | 4b. City, Town, or Location of Death Bethesda | | 4c. County of Death Montgomery |
| Funeral Director | 5. Social Security Number 371-14-7647 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 79 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) November 16, 1917 | | 9. Birthplace (State or Foreign Country) Michigan | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | |
| | 10a. State Maryland | 10b. County Montgomery | 10c. City, Town or Location Bethesda | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10e. Street and Number 4503 Middleton Lane | | 10f. Zip Code 20814 | | 10g. Citizen of What Country? United States |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Engineer | | 16b. Kind of Business/Industry General Motors | | |
| | 17. Father's Name (First, Middle, Last) Anthony Nowlinski | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Nowoczynski | | |
| | 19a. Informant's Name/Relationship (Type, Print) Genevieve Ghaed/Daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4503 Middleton Lane, Bethesda, Maryland 20814 | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc. | | 20c. Location - City or Town, State Bethesda, Maryland |
| | 21. Signature of Funeral Service Licensed <i>Michael E. Higgins</i> M00846 | | 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Chronic Obstructive Lung Disease Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death 10 Years |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how Injury occurred | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| | 29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | |
| | 29b. Signature and title of certifier <i>Anthony I. Corvelli</i> | | 29c. License number D23592 | | 29d. Date signed (Month, Day, Year) July 31, 1997 |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anthony I. Corvelli, M.D., 5530 Wisconsin Avenue #1400, Chevy Chase, Maryland 20815 | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) AUG 04 1997 | | 32. Registrar's Signature <i>John Davidson-Randall</i> | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Item #10g, Per F.D. State of Maryland / Department of Health and Mental Hygiene 97 25076
8/6/97, Carroll County, wjl

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|---|--|---|--|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Louise S. Nusbaum | | | | 2. Date of Death Month 8 Day 3 Year 97 | | | | 3. Time of Death 1:53 pm | |
| | 4a. Facility Name (If not institution, give street and number) Ivy Hall Geriatric Center 1300 Windlass Dr. | | | | 4b. City, Town, or Location of Death Baltimore Md | | | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 28-09-3279 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (in yrs. last birthday) 92 Yrs. | | 8. Date of Birth (Month, Day, Year) Mar. 21, 1905 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | 10a. State MD | | | | 10b. County Baltimore | | 10c. City, Town or Location Ivy Hall Geriatric Center 1300 Windlass Dr. | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Funeral Director | 10e. Street and Number 1300 Windlass Dr. | | | | 10f. Zip Code 21220 | | 10g. Citizen of What Country? U.S.A. | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) seamstress | | | | 16b. Kind of Business/Industry clothing mfg. | |
| | 17. Father's Name (First, Middle, Last) Parker Eyler | | | | 18. Mother's Name (First, Middle, Maiden Surname) Emma Susan Beard | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Phyllis M. Resh/ daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1517 Weyburn Rd. Baltimore, MD 21237 | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mountain View Cemetery | | Date 8/6/97 | | 20c. Location - City or Town, State Union Bridge, MD | | | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee Catherine O. Hartzler | | | | 22. Name and Address of Facility Hartzler Funeral Home Union Bridge, MD | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Possible Acute MI Due to (or as a consequence of): b. 1 1/2 yrs Dementia Due to (or as a consequence of): c. Bad Reaction Due to (or as a consequence of): d. Osteoporosis | | | | Approximate Interval Between Onset and Death 1 hr 2+y 3+y 10+y | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA | | 26. Place of Death (Check only one) Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier | | 29c. License number D14221 | | 29d. Date signed (Month, Day, Year) 8.4.97 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) T.A. Fikow 223 B. Blvd BALT MD 21221 | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) AUG 06 1997 | | 32. Registrar's Signature John Davidson-Randall | | | | | | | |

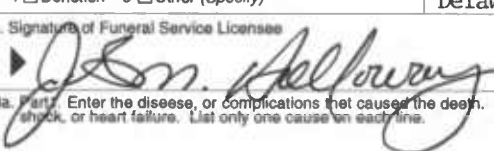
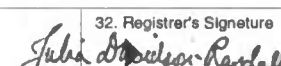


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25077

Amended #20a 20b WCHD 8/13/97 de Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) George Oliver | | | | 2. Date of Death Month 8 Day 2 Year 97 | | 3. Time of Death 0950 | |
| | 4a. Facility Name (If not institution, give street and number) Peninsula Regional | | | | 4b. City, Town, or Location of Death Salisbury | | 4c. County of Death Wicomico | |
| Funeral Director | 5. Social Security Number 189-30-0963 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 57 Yrs. | | 8. Date of Birth (Month, Day, Year) March 6, 1940 | |
| | 9. Birthplace (State or Foreign Country) Pennsylvania | | 10a. State Pennsylvania | | 10b. County Bucks | | 10c. City, Town or Location Warminster | |
| To Be Completed by Funeral Director | Usual Residence of Decedent 10a. State Pennsylvania | | | | 10b. County Bucks | | 10c. City, Town or Location Warminster | |
| | 10d. Inside City Limits <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | 10e. Street and Number 359 Marilyn Road | | 10f. Zip Code 18974 | |
| | 10g. Citizen of What Country? USA | | | | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) - | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter | | 16b. Kind of Business/Industry Carpentry | |
| | 17. Father's Name (First, Middle, Last) Robert Johnson Oliver | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mildred Rogers | | | |
| | 19a. Informant's Name/Relationship (Type, Print) B. Kathleen Oliver/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 359 Marilyn Rd., Warminster, PA 18974 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Delaware Valley Crematory | | 20c. Location - City or Town, State Southampton, PA | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21804 | | | |
| | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Congestive Cardiomyopathy Due to (or as a consequence of): b. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | Approximate Interval Between Onset and Death | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier  DME | | 29c. License number D03599 | | 29d. Date signed (Month, Day, Year) 8-02-97 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John T. Bulkeley, M.D. 108 Pine Bluff Rd. Salisbury, Md. 21801 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 05 1997 | | 32. Registrar's Signature  | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

12

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25078

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HESTER

2. Date of Death
Month Day Year

PROCTOR

August 2, 1997

3. Time of Death

2:36 pm

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

239 28 4201

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

August 26, 1915

9. Birthplace (State or Foreign Country)

Mary Hill, N.C.

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

Washington, D.C.

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

539 Riggs Rd., N.E.

10f. Zip Code

20011

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☐ Yes 2 ☒ NoIf Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify:

Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Clerk Typist

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Joseph Rodgers

18. Mother's Name (First, Middle, Maiden Surname)

Hester Perry

19a. Informant's Name/Relationship (Type, Print)

Jon H. Proctor (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

539 Riggs Rd., N.E., Washington, D.C. 20011

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Mt. Olivet Cemetery

Date

8/9/97

20c. Location - City or Town, State

Washington, D.C.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McGuire Funeral Service Inc.

7400 Georgia Ave., N.W., Washington, D.C. 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

CARCINOMA OF BREAST

Approximate
Interval Between
Onset and Death

2 MONTHS

Due to (or as a consequence of):

METASTASIS TO BONES

2 MONTHS

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC BRONCHITIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending
Investigation6 ☐ Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

V. Singh Attend. Phys.

29c. License number

D19897

29d. Date signed (Month, Day, Year)

8.3.97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

V. SINGH 7209 A HANOVER PARKWAY GREENBELT MD

31. Date filed (Month, Day, Year)

AUG 5 1997

32. Registrar's Signature

John Davidson-Randall

20772

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

20

HESTER PROCTOR

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25079

Certificate of Death

Reg. No.

1. Decedent's Name (First, Middle, Last)

Imants I. Plavnieks

2. Date of Death

August 1, 1997

3. Time of Death

3:50 AM

4a. Facility Name (If not institution, give street and number)

Care Matrix Nursing Center

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

578-42-6644

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Jan. 8, 1925

9. Birthplace (State or Foreign Country)

Latvia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Garrett Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4604 Strathmore Avenue

10f. Zip Code

20896

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cabinet Maker

16b. Kind of Business/Industry

Manufacturing

17. Father's Name (First, Middle, Last)

Gustavs Plavnieks

18. Mother's Name (First, Middle, Maiden Surname)

Wmilija Villers

19a. Informant's Name/Relationship (Type, Print)

Irma Plavnieks

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4604 Strathmore Avenue Garrett Park, Maryland 20896

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rock Creek Cemetery

Date

8/4/97

20c. Location - City or Town, State

Washington, D.C.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.
500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Respiratory Failure

Severe Parkinson's Disease

Pneumonia

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D35791

29d. Date signed (Month, Day, Year)

8/1/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Merlyn K. Vemury, M.D. 9801 Georgia Avenue #227 Silver Spring, Maryland 20902

31. Date filed (Month, Day, Year)

August 4, 1997

32. Registrar's Signature

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

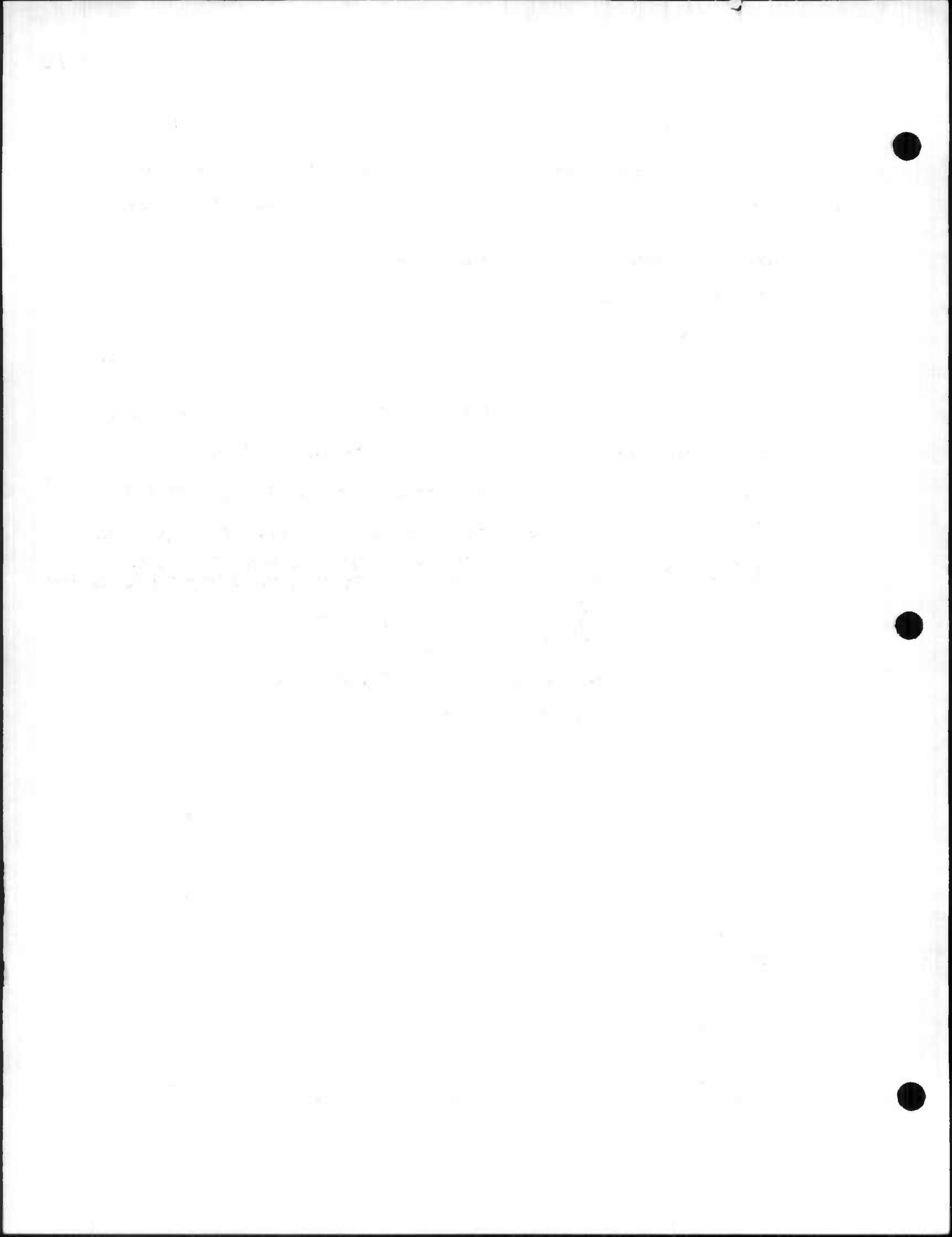
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25080

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

James R. Parker

2. Date of Death

Month Day Year
July 31 1997

3. Time of Death

9:20AM

4a. Facility Name (If not institution, give street and number)

Laurel Regional Hospital

4b. City, Town, or Location of Death

Laurel

4c. County of Death

PRINCE GEORGES

Funeral
Director

5. Social Security Number

238-20-9503

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Aug. 13, 1923

9. Birthplace (State or Foreign Country)

N. Carolina

Usual Residence of Decedent

10a. State

MD

10b. County

Prince Georges

10c. City, Town or Location

Laurel

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

7014 Scotch Drive

10f. Zip Code

20707

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 44-4613. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4 yrs

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Security Guard

16b. Kind of Business/Industry

G.S.A.

17. Father's Name (First, Middle, Last)

Marion Parker

18. Mother's Name (First, Middle, Maiden Surname)

Minnie Moose

19a. Informant's Name/Relationship (Type, Print)

Eunice L. Parker

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7014 Scotch Dr., Laurel, MD 20707

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Quantico Nat'l Cem. 8/6/97

Date

20c. Location - City or Town, State

Triangle, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SNOWDEN FUNERAL HOME, P.A.
ROCKVILLE, MD 20850

Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)a. ACUTE MYOCARDIAL INFARCTION
Due to (or as a consequence of):

< 1 Hr

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. CORONARY ARTERY DISEASE
Due to (or as a consequence of):

5 YRS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient3 ☐ DOAOther: 4 ☐ Nursing Home5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 22755

29d. Date signed (Month, Day, Year)

7-31-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7350 VAN DYSEN ROAD #260 LAUREL MD 20707

31. Date filed (Month, Day, Year)

AUG 4 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25081

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedant's Name (First, Middle, Last)

Alejandro Palau

2. Date of Death

Month July 31, Day Year 1997

3. Time of Death

9:30 pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

5. Social Security Number

219-34-7797

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) March 31, 1917

9. Birthplace (State or Foreign Country)

Mexico

Usual Residence of Decedant

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

College Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7101 Rhode Island Avenue

10f. Zip Code

20740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☒ Yes 2 ☐ No Specify:
Mexican14. Race - American Indian,
Black, White, etc.Specify:
Other

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working
life. DO NOT use retired)

Legislator

16b. Kind of Business/Industry

Politics

17. Father's Name (First, Middle, Last)

Gilberto Palau

18. Mother's Name (First, Middle, Maiden Surname)

Maria Luz De La Vega

19a. Informant's Name/Relationship (Type, Print)

Grace P. Ballenger

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8924 Bel Air Place Potomac, Maryland 20854

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metropolitan Crematory

Date

8/01/97

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

Eric S. Scarbo

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W., Silver Spring, MD 20901

23a. Pertinent, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

a. Coronary Artery Disease

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

months

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

James L. Cockrell, M.D.

29c. License number

44751

29d. Date signed (Month, Day, Year)

July 31, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James L. Cockrell, M.D. 7600 Carroll Ave., Takoma Park, MD 20912

31. Date filed (Month, Day, Year)

AUG 07 1997

32. Registrar's Signature

John Davidson-Rodella

State
Registrar

Baltimore, Maryland 21215-0020

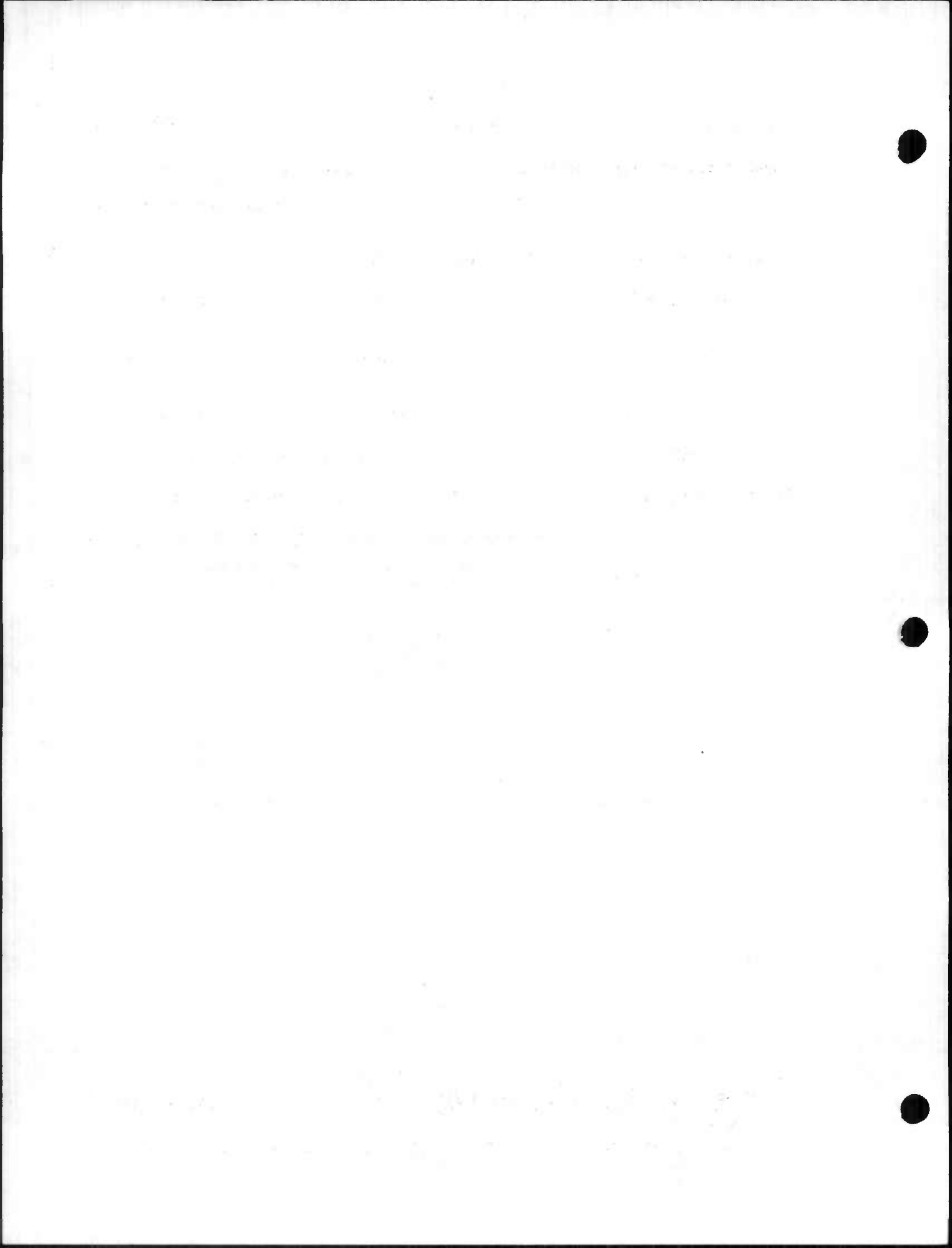
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25082

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John Ruby Proctor

2. Date of Death

Month Day Year
August 07, 1997

3. Time of Death

10:55PM

4a. Facility Name (If not institution, give street and number)

Physicians Memorial Hospital

4b. City, Town, or Location of Death

La Plata

4c. County of Death

Charles

Funeral
Director

5. Social Security Number

213-22-0132

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

69

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
November 27, 1927

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

Indian Head

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5418 Stuckey Rd.

10f. Zip Code

20640

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

John Ruby Proctor, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Sarah Elsie Thompson

19a. Informant's Name/Relationship (Type, Print)

Mary Green (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

505 Apt. B1, Wilson Bridge Dr. Oxon Hill, Md. 20745

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

August 12, 1997

St. Catherine's Cemetery

20c. Location - City or Town, State

McConchie, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Williams Funeral Home

M00668 4270 Hawthorne Rd. Indian Head, Maryland 20640

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a.

Cardio Pulmonary Arrest

Due to (or as a consequence of):

b.

Acute Myocardial Infarction

Due to (or as a consequence of):

c.

Hypertension

Due to (or as a consequence of):

d.

Insulin Dependent Diabetes Mellitus

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

8/7/97

Yrs

Yrs.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient3 ☒ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician:

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner:

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D-46979

29d. Date signed (Month, Day, Year)

8/8/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Collins Po Sein, MD., 11345 Pembroke Square, Suite 104, Waldorf, Maryland 20603

31. Date filed (Month, Day, Year)

AUG 11 1997

32. Registrar's Signature

John Davidson Randall

State
Registrar

John Ruby Proctor
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
202-251-0028.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

2005

[Handwritten signature]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25083
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LOTTIE M. ROZIER

2. Date of Death

Month August Day 3, Year 1997

3. Time of Death

9:30 PM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

218-20-2258

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 1, 1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Takoma Park

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7521 Blair Road, #13

10f. Zip Code

20912

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10th

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Moses Boyd

18. Mother's Name (First, Middle, Maiden Surname)

Virginia Smith

19a. Informant's Name/Relationship (Type, Print)

Alfreda Rozier (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

943 Clopper Rd., #B2, Gaithersburg, MD 20878

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Ash Memorial Cem.

Date

8/8/97

20c. Location - City or Town, State

Sandy Spring, MD

21. Signature of Funeral Service Licensee

George R. Snowden

22. Name and Address of Facility

SNOWDEN FUNERAL HOME, P.A.

ROCKVILLE, MD 20850

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Anoxic encephalopathy*

Due to (or as a consequence of):

2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *cardiac arrhythmia*

Due to (or as a consequence of):

2 days

c. *myocardial infarction*

Due to (or as a consequence of):

4 days

d. *coronary artery disease*

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Ruth Kevers Cohen, MD

29c. License number

D 33159

29d. Date signed (Month, Day, Year)

Aug. 4, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Ruth Kevers Cohen, MD 8700 Georgia Ave # 400 Silver Spring MD 20910

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

*Julia Davidson-Randall*State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25084

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Agnes C. Rohman

2. Date of Death

Month Day Year
August 4, 1997

3. Time of Death

11:50PM

4a. Facility Name (If not Institution, give street and number)

Mediplex-Gaithersburg

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

218-12-5499

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

(Month, Day, Year)

Nov. 6, 1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1017 Scott Avenue

10f. Zip Code

20851

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John Rohman

18. Mother's Name (First, Middle, Maiden Surname)

Clara Egan

19a. Informant's Name/Relationship (Type, Print)

Mary Jane Zeek/Cousin

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1017 Scott Avenue, Rockville, Maryland 20851

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Montgomery Crematorium, Inc.

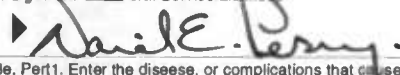
Date

August 6, 1997

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/
Rockville, Inc. 300 West Montgomery Avenue
Rockville, Maryland 20850-280523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

b. Hypertension

Due to (or as a consequence of):

c. Anxiety

Due to (or as a consequence of):

d. Glaucoma

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier



29c. License number

D43272

29d. Date signed (Month, Day, Year)

August 5, 1997


30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Sunita Hanjura, M.D. 809 Veirs Mill Road, #101, Rockville, Maryland 20851

31. Date filed (Month, Day, Year)

AUG 07 1997

32. Registrar's Signature


State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25085

| | | | | | | | | |
|--|--|---|---|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Frances H. Risen | | | | 2. Date of Death Month Day Year August 2, 1997 | | 3. Time of Death 6:10 AM | |
| | 4a. Facility Name (If not institution, give street and number) Suburban Hospital | | | | 4b. City, Town, or Location of Death Bethesda | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 305-07-4856 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 83 Yrs. | | 8. Date of Birth (Month, Day, Year) July 19, 1914 | |
| | 9. Birthplace (State or Foreign Country) Illinois | | 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Bethesda | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | 10e. Street and Number 9831 Singleton Drive | | | | 10f. Zip Code 20817 | | 10g. Citizen of What Country? United States | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Agent | | 16b. Kind of Business/Industry Real Estate | | | |
| | 17. Father's Name (First, Middle, Last) James Francis Goodman | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Gertrude Ledman | | | |
| | 19a. Informant's Name/Relationship (Type, Print) James E. Risen/Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7712 Baederwood Terrace, Derwood, Maryland 20855 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery | | Date August 5, 1997 | | 20c. Location - City or Town, State Silver Spring, Maryland | |
| | 21. Signature of Funeral Service Licensee <i>Michael E. Higgins</i> M00846 | | | | 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | Approximate Interval Between Onset and Death | | | |
| | Immediate Cause (Final disease or condition resulting in death) Cerebrovascular Accident Due to (or as a consequence of): Cerebrovascular disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Pneumonia, Congestive heart failure, Acute myocardial infarction, adult respiratory distress Syndrome | | | | 9 days years | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pneumonia, Congestive heart failure, Acute myocardial infarction, adult respiratory distress Syndrome | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>Lee R. Pennington, MD</i> | | 29c. License number D21115 | | 29d. Date signed (Month, Day, Year) 8/2/97 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lee R. Pennington, M.D., 5602 Shields Drive, Bethesda, MD. 20817 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 4 1997 | | 32. Registrar's Signature <i>John Anderson-Rodriguez</i> | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

20

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25086

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|--|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last) Winifred M. Richardson | | | | 2. Date of Death Month August Day 3 Year 1997 | | 3. Time of Death 4:00 PM | |
| 4a. Facility Name (If not institution, give street and number) ManorCare Health Services | | | | 4b. City, Town, or Location of Death Bethesda | | 4c. County of Death Montgomery | |
| 5. Social Security Number 579-09-8939 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 78 Yrs. | If Under 1 Year Months | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) October 5, 1918 | |
| 9. Birthplace (State or Foreign Country) Nebraska | | | | | | | |
| 10e. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Chevy Chase | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 7221 Delfield Street | | | | 10f. Zip Code 20815 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Real Estate Agent | | 16b. Kind of Business/Industry Realtors | | | |
| 17. Father's Name (First, Middle, Last) Edward Wolverton | | | | 18. Mother's Name (First, Middle, Maiden Surname) Vera Geisler | | | |
| 19a. Informant's Name/Relationship (Type, Print) Bill Richardson Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10205 Frederick Avenue, Kensington, Maryland 20895 | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory | | Date 8-4-97 | | 20c. Location - City or Town, State Beltsville, Maryland | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, MD 20910 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Metastatic Gastric Carcinoma Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death Months | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number D42518 | | 29d. Date signed (Month, Day, Year) August 4, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gul Chablani, M.D., 11119 Rockville Pike #316, Rockville, MD 20852 | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 5 1997 | | | | 32. Registrar's Signature  | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25087

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy Helen Strode

2. Date of Death

Month Day Year
August 3, 1997

3. Time of Death

9:30 AM

4a. Facility Name (If not institution, give street and number)

101 Odendhal Ave., # 908

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

041-60-7127

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
April 5, 1914

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

101 Odendhal Ave., # 908

10f. Zip Code

20877

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Carl Page

18. Mother's Name (First, Middle, Maiden Surname)

Edith Eaton

19a. Informant's Name/Relationship (Type, Print)

Sally Anne Snider/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9809 Maple Leaf Drive, Gaithersburg, MD. 20879

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metropolitan Crematory

Date

8/4/97

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

Michael D. Cielbas

22. Name and Address of Facility

DeVol Funeral Home

10 East Deer Park Dr., Gaithersburg, MD. 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

Ventricular arrhythmia

Due to (or as a consequence of):

b.

Chronic premature ventricular contractions

Due to (or as a consequence of):

c.

asthma

Due to (or as a consequence of):

d.

corticosteroid dependence

Approximate
Interval Between
Onset and Death

0 minutes

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Marilyn E. Giles M.D.

29c. License number

D34373

29d. Date signed (Month, Day, Year)

August 4, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Marilyn E. Giles, M.D., 19642 Club House Rd., # 615, Gaithersburg, MD. 20879-3046

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

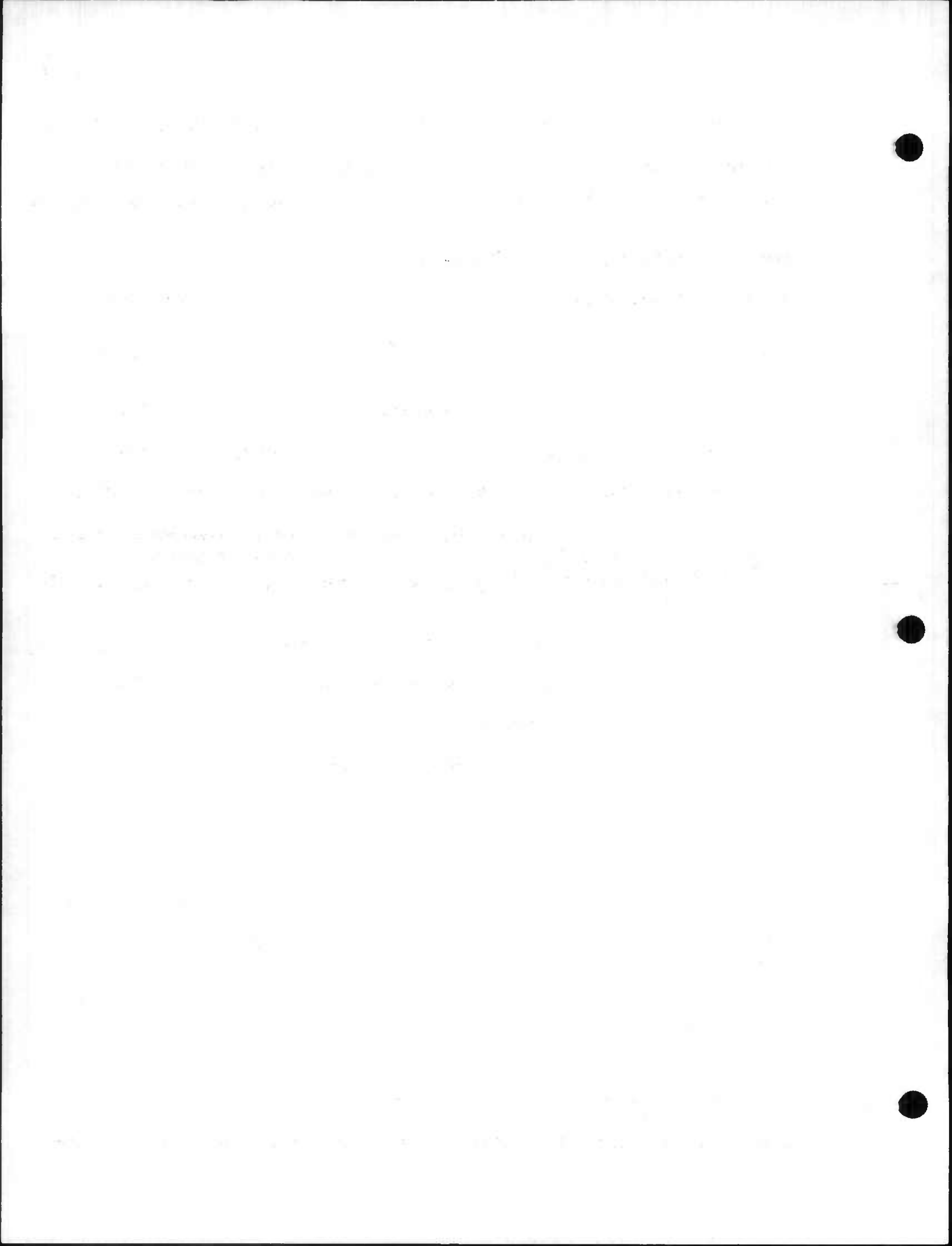
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25088

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Virginia Wayman Sprankle

2. Date of Death

Month Day Year
July 26, 1997

3. Time of Death

6:35 pm

Funeral
Director

4e. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

578-62-3036

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 11, 1906

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5829 Osceola Road

10f. Zip Code

20816

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Albert J. Wayman

18. Mother's Name (First, Middle, Maiden Surname)

Annabelle / Not Available

19a. Informant's Name/Relationship (Type, Print)

Patricia Marsh/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9033 Willow Valley Drive Potomac, Maryland 20854

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Arlington National Cemetery

Date

August 1, 1997

20c. Location - City or Town, State

Arlington, Virginia

21. Signature of Funeral Service Licensee

M00335

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/

Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue

Bethesda, Maryland 20814-3501

23e. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Gangrene Right Foot

Due to (or as a consequence of):

6 Weeks

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Arteriosclerosis

Due to (or as a consequence of):

Years

c. Dementia

Due to (or as a consequence of):

Years

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

JAMES SALANDER

29c. License number

D39064

29d. Date signed (Month, Day, Year)

July 28, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James M. Salander M.D. 11119 Rockville Pike #204 Rockville, Maryland 20852-3143

31. Date filed (Month, Day, Year)

August 4, 1997

32. Registrar's Signature

John Davidson-Rodriguez

State
RegistrarBaltimore, Maryland 21215-0020
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25089

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|---|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Thomas Edward Sipple | | | | 2. Date of Death Month Day Year August 7, 1997 | | 3. Time of Death 8:15A.M. | |
| | 4e. Facility Name (If not institution, give street and number) Manor Care-Bethesda | | | | 4b. City, Town, or Location of Death Bethesda | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 577-20-4477 | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 71 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) August 16, 1925 | | 9. Birthplace (State or Foreign Country) Pennsylvania |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State None | | 10b. County None | | 10c. City, Town or Location Washington, D.C. | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| | 10e. Street and Number 3130 Wisconsin ave., N.W. #703 | | | | 10f. Zip Code 20016 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 43-46 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Para-Legal | | | 16b. Kind of Business/Industry Law Firm | | |
| | 17. Father's Name (First, Middle, Last) Thomas Francis Sipple | | | | 18. Mother's Name (First, Middle, Maiden Surname) Florence Haggerty | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) David Morris/Nephew | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 47783 Tupelo Ct. Sterling, Va. 20165 | | | |
| | 20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Quantico Nat'l Cemetery | | Date 8/11/97 | | 20c. Location - City or Town, State Quantico, Virginia | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility DeVol Funeral Home 2222 Wisc. Ave. NW Wash. D.C. 20007 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. COLON CANCER Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | Approximate Interval Between Onset and Death 6 MONTHS |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier HAMMETT MD | | 29c. License number D39966 | | 29d. Date signed (Month, Day, Year) 8/7/97 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CAROLYN A. HAMMETT, MD 901 SLIGO CREEK PKWY TAKOMA PARK, MD | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 08 1997 | | 32. Registrar's Signature  | | | | | | |

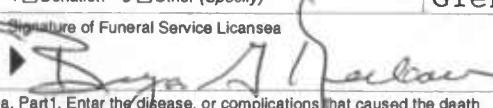
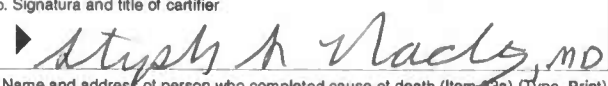
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25090

Items: 27, 28a-f per MEO G-751 9/30/97 dh
MALAKI SCALES

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|------------------------------------|---|--|---|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Malaki Scales | | | | 2. Date of Death Month Day Year JULY 30 1997 | | 3. Time of Death 12:47 PM | |
| | 4a. Facility Name (If not institution, give street and number) WASHINGTON ADVENTIST HOSPITAL | | | | 4b. City, Town, or Location of Death TAKOMA PARK | | 4c. County of Death MONTGOMERY | |
| Funeral Director | 5. Social Security Number 215-35-2471 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 10 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) March 11, 1987 | 9. Birthplace (State or Foreign Country) Eden, NC |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | 10b. County Anne Arundel | | 10c. City, Town or Location Glen Burnie | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number 442 Rodgers Avenue | | | | 10f. Zip Code 21060 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) None | | | 16b. Kind of Business/Industry Student | | |
| | 17. Father's Name (First, Middle, Last) Ma;aki Iaula | | | | 18. Mother's Name (First, Middle, Maiden Surname) Robin Scales | | | |
| Physician /Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Robin Scales / Mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 442 Rodgers Ave., Glen Burnie, MD 21060 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Glenwood Cemetery | | Date 8/4/97 | 20c. Location - City or Town, State Washington, DC | | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Takoma Funeral Home 254 Carroll St., NW, Wash. DC 20012 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Diabetic ketoacidosis Due to (or as a consequence of): Sequitentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 5. Pending investigation <input type="checkbox"/> Could not be determined <input type="checkbox"/> | | 28a. Date of Injury (Month, Day Year) 7/30/97 found | | 28b. Time of Injury unknown M | |
| | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 28d. Describe how Injury occurred insulin withheld | | | |
| | 28e. Place of Injury - At home, farm, street, tactory, office building, etc. (Specify) home | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 911 Glazewood Avenue, Tokoma Park, Maryland | | | |
| | 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier  Stephen S. Radentz, MD | | | |
| 29c. License number O.C.M.E. | | | | 29d. Date signed (Month, Day, Year) JULY 31, 1997 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 05 1997 | | | | 32. Registrar's Signature  | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25091

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|--|---|--|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Ernest Delmore Sampson | | | | 2. Date of Death Month August 4 Day 1997 Year | | 3. Time of Death 12:25 PM | | |
| | 4a. Facility Name (If not institution, give street and number) Springbrook Adventist Nursing Home | | | | 4b. City, Town, or Location of Death Silver Spring | | 4c. County of Death Montgomery | | |
| Funeral Director | 5. Social Security Number 144-16-6023 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 92 Yrs. | | 8. Date of Birth (Month, Day, Year) Dec. 26, 1904 | | |
| | 9. Birthplace (State or Foreign Country) Massachusetts | | 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Silver Spring | | |
| Usual Residence of Decedent | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 13720 Bridgewater Drive | | 10f. Zip Code 20904 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Salesman | | 16b. Kind of Business/Industry Industrial Scales | | | | | |
| 17. Father's Name (First, Middle, Last) John Ernest Sampson | | | | 18. Mother's Name (First, Middle, Maiden Surname) Emma Bissett | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Caral Ann Giammo / Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13720 Bridgewater Drive, Silver Spring, MD 20904 | | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Crematory | | Date 8/6/97 | | 20c. Location - City or Town, State Brentwood, Maryland | | | |
| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death < 1 hr. | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | 26. Place of Death (Check only one) Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier M. S. Nayar | | 29c. License number D-17874 | | 29d. Date signed (Month, Day, Year) 8-4-97 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) S. M. NAYAR, MD. 3717-38th Ave, BRENTWOOD, MD 20722 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 08 1997 | | 32. Registrar's Signature John Davidson-Randall | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25092

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Herbert Thatcher Smith Jr.

2. Date of Death

Month Day Year
August 6, 1997

3. Time of Death

11:00 am

4a. Facility Name (If not institution, give street and number)

3150 Cardinal Drive

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

Funeral
Director

5. Social Security Number

213-30-4282

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
April 26, 1932

9. Birthplace (State or Foreign Country)

Mass.

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Westminster

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3150 Cardinal Drive

10f. Zip Code

21157

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1952 - 195513. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

clerk

16b. Kind of Business/Industry

Post Office

17. Father's Name (First, Middle, Last)

Herbert Thatcher Smith Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Marguerite Murphy

19a. Informant's Name/Relationship (Type, Print)

Patricia Ann Smith, wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3150 Cardinal Drive, Westminster, MD 21157

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Garrison Forest Cemetery

Date
08/08/97

20c. Location - City or Town, State

Owings Mills, MD

21. Signature of Funeral Service Licensee

Katherine Pites - Sweitzer

22. Name and Address of Facility

Pites Funeral Home & Chapel

412 Washington Rd., Westminster, MD 21157

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. METASTATIC PROSTATE CA

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Sup

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

BLADDER CA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)

29b. Signature and title of certifier

Flavio Kruter

29c. License number

D35398

29d. Date signed (Month, Day, Year)

8/6/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Flavio Kruter, MD - 684A Poole Rd - Westminster, MD 21157

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

John Andrew Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25093

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Diane B. Tyner

2. Date of Death

Month Day Year
August 1, 1997

3. Time of Death

7:15 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

10007 Vanderbilt Circle #11

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

135-36-4836

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

49 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
January 6, 1948

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

10007 Vanderbilt Circle #11

10f. Zip Code

20850

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Word Processor

16b. Kind of Business/Industry

Kaiser-Permanente

17. Father's Name (First, Middle, Last)

Percy Stanley

18. Mother's Name (First, Middle, Maiden Surname)

Lovell Dent

19a. Informant's Name/Relationship (Type, Print)

Casaundra Y. Thomas Partner

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10007 Vanderbilt Circle #11, Rockville, Maryland 20850

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Chesapeake Crematory

Date

8-2-97

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Rapp Funeral Services, P.A.
933 Gist Avenue, Silver Spring, Maryland 2091023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Cerebral Edema

Due to (or as a consequence of):

b. CNS Lymphoma

Due to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HIV/AIDS

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
Investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier

29c. License number

D50030

29d. Date signed (Month, Day, Year)

August 2, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

David Rogers, M.D.

7474 Greenway Center Drive #800, Greenbelt, Maryland 20770

31. Date filed (Month, Day, Year)

AUG 05 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25094

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|---|---|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Gary Forrest Trickett | | | | 2. Date of Death Month August Day 3 Year 1997 | | 3. Time of Death 11:30 PM | |
| | 4a. Facility Name (If not institution, give street and number) Montgomery General Hospital | | | | 4b. City, Town, or Location of Death Olney | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 233-74-4760 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 38 Yrs. | | 8. Date of Birth (Month, Day, Year) Nov. 27, 1958 | |
| | 9. Birthplace (State or Foreign Country) West Virginia | | 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Germantown | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 12209H St. Peters Court | | 10f. Zip Code 20874 | | 10g. Citizen of What Country? United States | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No, if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Computer Specialist | | 16b. Kind of Business/Industry Computer | | 16c. Kind of Business/Industry | |
| | 17. Father's Name (First, Middle, Last) Forrest Virgil Trickett, Jr. | | 18. Mother's Name (First, Middle, Maiden Surname) Freda Hamner | | 19a. Informant's Name/Relationship (Type, Print) Cheryl A. Welling/Sister | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 157 Cedar Road, Strasburg, Virginia 22657 | |
| Physician /Medical Examiner | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Maplewood Cemetery | | Date Aug. 7, 1997 | | 20c. Location - City or Town, State Elkins, West Virginia | |
| | 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility DeVol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD. 20877 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. METASTATIC colon carcinoma b. Crohn's Disease | | Approximate Interval Between Onset and Death 3 1/2 YEARS 18 YEARS | |
| Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural" or item 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once. | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of injury (Month, Day, Year) | | 28b. Time of injury M | | 28c. Injury at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| State Registrar | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and Title of certifier  | | 29c. License number D 35635 | | 29d. Date signed (Month, Day, Year) August 4, 1997 | |
| 30. Name and address of person who completed cause of death (item 23a) (Type, Print) JOSEPH KAPLAN 18111 Prince Philip Dr. OLNEY, MD 20832 | | 31. Date filed (Month, Day, Year) AUG 06 1997 | | 32. Registrar's Signature  | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25095

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|---------------------------|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MICHAEL J. TORRES | | | | 2. Date of Death Month Day Year JULY 30, 1997 | | 3. Time of Death 11:00AM | |
| | 4a. Facility Name (If not institution, give street and number) PRINCE GEORGES GENERAL HOSPITAL | | | | 4b. City, Town, or Location of Death CHEVERLY | | 4c. County of Death PRINCE GEORGES | |
| Funeral Director | 5. Social Security Number 451-57-5057 | | 6. Sex 15 M 2 F | | 7. Age (In yrs. last birthday) 18 Yrs. | | 8. Date of Birth (Month, Day, Year) AUG. 23, 1978 | |
| | 9. Birthplace (State or Foreign Country) CALIFORNIA | | 10a. State TX. | | 10b. County CAMERON | | 10c. City, Town or Location SANTA ROSA | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 Yes 2 No | | | | 10e. Street and Number RT 1 BOX 176 | | 10f. Zip Code 78593 | |
| | 10g. Citizen of What Country? U.S.A. | | | | 11. Marital Status 1 X Never Married 2 No Married | | 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Yes 2 No Specify: MEXICAN | | | | 14. Race - American Indian, Black, White, etc. Specify: HISPANIC | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) U. S. NAVY | | | |
| | 16b. Kind of Business/Industry DEFENSE | | | | 17. Father's Name (First, Middle, Last) PLUTARCO TORRES | | | |
| | 18. Mother's Name (First, Middle, Maiden Surname) SUSANA VILLARREA | | | | 19e. Informant's Name/Relationship (Type, Print) SUSANA TORRES/MOTHER | | | |
| | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS ITEM #10 | | | | 20e. Method of Disposition 1 X Burial 2 No Cremation 3 No Removal from State 4 No Donation 5 Other (Specify) | | | |
| | 20b. Place of Disposition (Name of cemetery, crematory or other place) SANTA ROSA CEMETERY | | | | 20c. Location - City or Town, State 8/5/97 SANTA ROSA, TX. | | | |
| | 21. Signature of Funeral Service Licensee W.W. Chambers | | | | 22. Name and Address of Facility CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD 20737 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. BRAIN DEATH SEVERE HEAD INJURY MULTIPLE TRAUMA auto mobile accident | | | | 23b. Did tobacco use contribute to the cause of death? 1 No 2 X Yes 3 Probably 4 Unknown | | | |
| 23c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. Was an autopsy performed? 1 No 2 X Yes | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 No 2 X Yes | | | | 25. Was case referred to medical examiner? 1 X Yes 2 No | | | | |
| 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA Other: 4 No Nursing Home 5 Residence 6 Other (Specify) | | | | 27. Manner of Death 1 Natural 2 X Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined | | | | |
| 28a. Date of Injury (Month, Day Year) 7-27-97 | | | | 28b. Time of injury 03:55AM | | | | |
| 28c. Injury at Work? 1 No 2 X Yes | | | | 28d. Describe how injury occurred PASSENGER auto accident | | | | |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) STREET | | | | 28f. Location (Street and Number or Rural Route Number City or Town, State) DUNKIRK, MARYLAND SOUTHERN MARYLAND BLVD/HICKORY RIDGE ROAD | | | | |
| 29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier Dr. Muhammad Ali Khan | | | | |
| 29c. License number D 23242 | | | | 29d. Date signed (Month, Day, Year) AUG. 1st 1997 | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DR MOHAMMAD ALI KHAN 7741 BELLE PE DR GREEN BELT MD. 20770 | | | | 31. Date filed (Month, Day, Year) AUG 4 1997 | | | | |
| 32. Registrar's Signature J. Davidson-Randall | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25096

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARY E. TAYLOR

2. Date of Death

August 1, 1997

3. Time of Death

9:05.AM

4a. Facility Name (If not institution, give street and number)

19216 Warrior Brook Drive

4b. City, Town, or Location of Death

Germantown

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

212-38-4178

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb. 23, 1923

9. Birthplace (State or Foreign Country)

Wash. DC

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Germantown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

19216 Warrior Brook Drive

10f. Zip Code

20874

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

John A. Terry

18. Mother's Name (First, Middle, Maiden Surname)

Lillian Prather

19a. Informant's Name/Relationship (Type, Print)

James H. Taylor (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19216 Warrior Brook Dr., Germantown, MD 20874

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parklawn Mem. Cen.

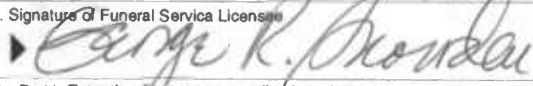
Date

8/7/97

20c. Location - City or Town, State

Rockville, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

SNOWDEN FUNERAL HOME, P.A.
ROCKVILLE, MD 20850

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. PNEUMONIA, PSEUDOMONAS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

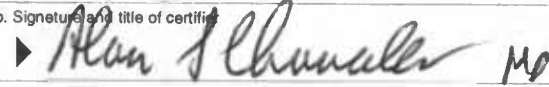
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

 MD

29c. License number

29453

29d. Date signed (Month, Day, Year)

August 1, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALAN S. CHANAYES 15225 Shady Grove Rd Rockville MD 20850

31. Date filed (Month, Day, Year)

AUG 4 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

97 25097

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Lettie Ruth Taylor | | | | 2. DATE OF DEATH MONTH August DAY 2 YEAR 1997 | | 3. TIME OF DEATH 12:10 A M | |
| 4. SOCIAL SECURITY NUMBER 242-26-6351 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 89 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Feb. 9, 1908 | |
| 8. BIRTHPLACE (State or Foreign Country) North Carolina | | | | 9a. FACILITY NAME (If not institution, give street and number) Mediplex Center | | 9b. CITY, TOWN OR LOCATION OF DEATH Gaithersburg | |
| 9c. COUNTY OF DEATH Montgomery | | | | 10a. STATE Maryland | | 10b. COUNTY Montgomery | |
| 10c. CITY, TOWN OR LOCATION Gaithersburg | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 8664 Delcris Drive | |
| 10f. ZIP CODE 20879 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 6 months | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Designer | | 16b. KIND OF BUSINESS/INDUSTRY Floral | | | |
| 17. FATHER'S NAME (First, Middle, Last) John B. Wacaster | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Nora Culkbertson | | | |
| 19a. INFORMANT'S NAME (Type/Print) Judy Formica | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8664 Delcris Drive, Gaithersburg, Maryland 20879 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) Fort Lincoln Crematory 8/6 | | 20c. LOCATION — City or Town, State Brentwood, Maryland | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | |
| 22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904 | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Breast Carcinoma Metastatic to Bones and Spine DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER S. Abdulfarag, M.D. | | 29c. LICENSE NUMBER 31391 D | | 29d. DATE SIGNED (Month, Day, Year) ► August 4, 1997 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) S. Abdulfarag, M.D. 481 N. Frederick Avenue #230, Gaithersburg, Maryland | | | | | | | |
| 31. DATE FILED Aug 4 1997 | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25098

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Charles Taylor | | | | 2. Date of Death Month July Day 29 Year 1997 | | 3. Time of Death 4:35p.m. | |
| | 4a. Facility Name (If not institution, give street and number) Deer's Head Center | | | | 4b. City, Town, or Location of Death Salisbury | | 4c. County of Death Wicomico | |
| Funeral Director | 5. Social Security Number 218-24-4080 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 68 Yrs. | | 8. Date of Birth (Month, Day, Year) August 7, 1928 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Somerset | | 10c. City, Town or Location Westover | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 7552 Lower Hill Rd | | 10f. Zip Code 21871 | | 10g. Citizen of What Country? U.S. of America | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver | | 16b. Kind of Business/Industry Poultry | | | |
| | 17. Father's Name (First, Middle, Last) Robert Henry Taylor | | 18. Mother's Name (First, Middle, Maiden Surname) Lottie Anne Simmons | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Agnes Louise Armstrong / friend | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7552 Lower Hill Rd Westover MD 21871 | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt Hope Church Cemetery | | 20c. Location - City or Town, State Princess Anne MD | | 20d. Date 08/2/97 | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee Joanne L Morris | | 22. Name and Address of Facility Lewis N Watson Funeral Home Salisbury, MD 21801 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Congestive heart failure Due to (or as a consequence of): b. congestive cardiomyopathy Due to (or as a consequence of): c. End stage renal disease Due to (or as a consequence of): d. Hypertension | | Approximate Interval Between Onset and Death 5 weeks 5 weeks 2-3 years many years | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus coronary artery disease | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Jo J Hwang, M.D. | | 29c. License number d16003 | | 29d. Date signed (Month, Day, Year) 7/29/97 | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) I.J. Hwang, M.D., P.O. Box 2018; Salisbury, Md. 21802 | | 31. Date filed (Month, Day, Year) AUG 01 1997 | | | | | |
| | 32. Registrar's Signature John Davidson-Randall | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25099

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Angelo V. Triglia

2. Date of Death

Month Day Year
July 25, 1997

3. Time of Death

1351

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral
Director

5. Social Security Number

217-30-9004

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

62 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 16, 1935

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

DE

10b. County

Sussex

10c. City, Town or Location

Delmar

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

705 E. State Street

10f. Zip Code

19940

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

General Manager

16b. Kind of Business/Industry

Trucking Co.

17. Father's Name (First, Middle, Last)

Joseph S. Triglia, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Mary A. Bellomo Triglia

19a. Informant's Name/Relationship (Type, Print)

Rosemary Lynch/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 187 Delmar, DE 19940

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

St. Stephens Cemetery

Date

8-1-97

20c. Location - City or Town, State

Delmar, Delaware

21. Signature of Funeral Service Licensee

William M. Shortt

22. Name and Address of Facility

Short Funeral Home, Inc.
13 East Grove St. Delmar, DE 1994023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause of death.Immediate Cause (Final
disease or condition
resulting in death)

a. asphyxian due to gross hemoptysis

Due to (or as a consequence of):

b. lung cancer

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

10 minutes

approx
1 year

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

COPD

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of causa
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

William M. Shortt

29c. License number

DL2160

29d. Date signed (Month, Day, Year)

July 25, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PRMC Salisbury and 21801 WILLIAM J NAGEL, MD

31. Date filed (Month, Day, Year)

JUL 31 1997

32. Registrar's Signature

Julia Davidson-Hartell

State
Registrar

Triglia, Angelo
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director


Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25100

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|----------------------------|--|--|--|--|---|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Benjamin Milton Trice | | | | 2. Date of Death Month August Day 2 Year 1997 | | 3. Time of Death 11:03 pm | |
| | 4a. Facility Name (If not institution, give street and number) Johns Hopkins Bayview Medical Center | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 218-09-7301 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 79 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) May 4, 1918 | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Delaware | 10b. County Kent | 10c. City, Town or Location Dover | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number 3203 White Oak Road | | | 10f. Zip Code 19901 | | 10g. Citizen of What Country? United States | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 6/44 If Yes, Give Year or Dates: 11/44 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Caucasian | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machinist | | 16b. Kind of Business/Industry Repair and construction of machinery | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Benjamin Silas Trice | | | | 18. Mother's Name (First, Middle, Maiden Surname) Florence Ellen Foxwell | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Benjamin C. Trice Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25325 Sandy Point Road, Greensboro, Maryland 21639 | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Capitol Crematory | | Date 8/5/97 | | 20c. Location - City or Town, State Dover, Delaware | |
| | 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629 | | | | | |
| Physician /Medical Examiner | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <u>Sepsis</u> Due to (or as a consequence of): b. <u>Extensive 2 and 3 degree burns</u> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Approximate Interval Between Onset and Death 4 days 8 days | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Renal Failure</u> | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | |
| | 24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) 7-27-97 | | 28b. Time of Injury 3:30P M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred steam boiler exploded | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 25325 SANDY POINT RD., GREENSBORO, MD. | | | | | |
| State Registrar | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| | 29b. Signature and title of certifier  | | | | 29c. License number 067912 | | 29d. Date signed (Month, Day, Year) August 4, 1997 | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Rodenck Bahner, MD | | | | 32. Registrar's Signature  | | | |
| | 31. Date filed (Month, Day, Year) AUG 06 '97 | | | | | | | |

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Released on Approval by Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25101

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|---|--|--|---|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) STANLEY WINGAST | | | | 2. Date of Death Month JUL Day 29 Year 1997 | | 3. Time of Death 4:25 PM | |
| | 4a. Facility Name (If not institution, give street and number) NATIONAL NAVAL MEDICAL CENTER | | | | 4b. City, Town, or Location of Death BETHESDA | | 4c. County of Death MONTGOMERY | |
| Funeral Director | 5. Social Security Number 104-18-2378 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (in yrs. last birthday) 71 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Aug. 15, 1925 | 9. Birthplace (State or Foreign Country) New York |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Virginia | | 10b. County Arlington | | 10c. City, Town or Location Arlington | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number 1600 S. Eads St. #105N | | | | 10f. Zip Code 22202 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Civil Engineer | | 16b. Kind of Business/Industry U.S. Navy | | | |
| | 17. Father's Name (First, Middle, Last) Bernard Weingast | | | | 18. Mother's Name (First, Middle, Maiden Surname) Lillian Gershenson | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Leda W. Davis | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3252 Grady Lane Woodbridge, VA 22192 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National | | 20c. Location - City or Town, State Arlington, VA | | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Ives-Pearson Funeral Homes 2847 Wilson Blvd. Arlington, VA 22201 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SEPSIS Due to (or as a consequence of): b. HEMOLYTIC ANEMIA Due to (or as a consequence of): c. HODGKINS DISEASE Due to (or as a consequence of): d. | | | | | | | |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier | | 29c. License number D-51503 | | 29d. Date signed (Month, Day, Year) 07/30/97 | | |
| 30. Name and address of person who completed cause of death (item 23e) (Type, Print) DAVID I. BLAZES, LT, MC, USN NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 4 1997 | | 32. Registrar's Signature | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

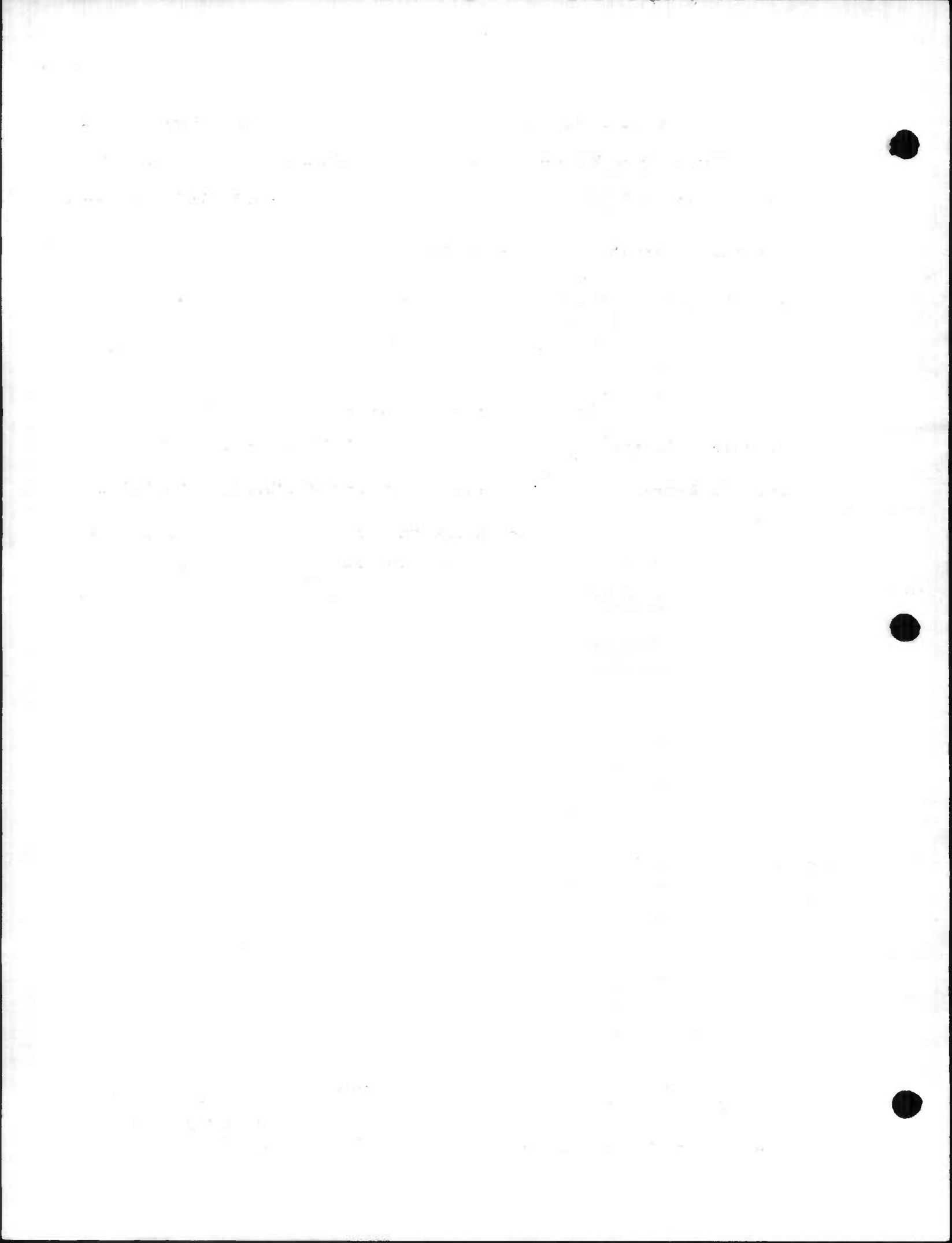
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25102

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Ann Wilkinson

2. Date of Death

August 4, 1997

3. Time of Death

7:52PM

4e. Facility Name (If not institution, give street end number)

309 Carl Street

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

259-22-7020

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 10, 1925

9. Birthplace (State or Foreign Country)

Georgia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street end Number

309 Carl Street

10f. Zip Code

20851

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Mark Sims

18. Mother's Name (First, Middle, Maiden Surname)

Mary Shields

19a. Informant's Name/Relationship (Type, Print)

William Hilton Wilkinson/Husband

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)

309 Carl Street, Rockville, Maryland 20851

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)August 6, 1997
Montgomery Crematorium, Inc.

Date

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

Raymond

M00198

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Rockville, Inc.
300 West Montgomery Avenue
Rockville, Maryland 20850-280523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)e. *metastatic lung cancer*
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

~ 9 months

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

None

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28e. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury et
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street end Number or Rural Route Number,
City or Town, State)29e. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Howard Saint, M.D.

29c. License number

D15552

29d. Date signed (Month, Day, Year)

8/6/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Howard Saint, M.D. 10810 Connecticut Ave. Kensington, Md 20895

31. Date filed (Month, Day, Year)

AUG 07 1997

32. Registrar's Signature

*John Davidson-Randall*State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25103

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Fred Werthan

2. Date of Death

August 4, 1997

3. Time of Death

9:31 AM

4a. Facility Name (If not institution, give street and number)

Fox Chase Rehabilitation and Nursing Center

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

057-16-1319

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

September 3, 1919

9. Birthplace (State or Foreign Country)

Germany

Usual Residence of Decedent

10e. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Chevy Chase

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8100 Connecticut Avenue

10f. Zip Code

20815

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates:
WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
White15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Executive

16b. Kind of Business/Industry

Pharmaceutical

17. Father's Name (First, Middle, Last)

Julius Werthan

18. Mother's Name (First, Middle, Maiden Surname)

Johanna Hirschowitz

19a. Informant's Name/Relationship (Type, Print)

Jeffrey Werthan

Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5325 Carvel Road, Bethesda, Maryland 20816

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Mount Moriah Cemetery

Date

8-6-97

20c. Location - City or Town, State

Fairview, New Jersey

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Rapp Funeral Services, P.A.
933 Gist Avenue, Silver Spring, MD 2091023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)e. UREMIA

Due to (or as a consequence of):

b. Arteriosclerotic Renal Vascular Disease

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

1 MONTH

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D01120

29d. Date signed (Month, Day, Year)

August 5, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Walter E. Goosz, M.D.

1299 Lamberton Drive, Silver Spring, Maryland 20902

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25104

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Sara Weiss

2. Date of Death

Month Aug. 1, 1997 Year

3. Time of Death

11:50PM

4a. Facility Name (If not institution, give street and number)

Hebrew Home of Greater Washington

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

577-10-9143

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) Nov. 13, 1917

9. Birthplace (State or Foreign Country)

Russia

Usual Residence of Decedent

10a. State

Md.

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6121 Montrose Rd.

10f. Zip Code

20852

10g. Citizen of What Country?

US

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working

life. DO NOT use retired)

Sales

16b. Kind of Business/Industry

Jewelry/Clothing

17. Father's Name (First, Middle, Last)

Nathan Steffel

18. Mother's Name (First, Middle, Maiden Surname)

Jenny Strickland

19a. Informant's Name/Relationship (Type, Print)

Sandra Shane/Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1729 Glastonberry Rd. Rockville, Md. 20854

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Mt. Lebanon Cemetery 8/3/97

Date

20c. Location - City or Town, State

Adelphi, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Edward Sagel Funeral Direction

1091 Rockville Pike Rockville, Md. 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. METASTATIC CARCINOMA OF BLADDER 2 YEARS

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

STEVEN LIPSON 6121 MONTROSE ROAD, ROCKVILLE, MD

31. Date filed (Month, Day, Year)

AUG 05 1997

32. Registrar's Signature

John Davidson-Rendall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25105

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARY WEIL

2. Date of Death

Month Day Year
AUGUST 2 1997

3. Time of Death

5:15 PM

4a. Facility Name (If not institution, give street and number)

COLLINGSWOOD NURSING AND REHABILITATION CNTR. ROCKVILLE

4b. City, Town, or Location of Death

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

054-10-0559

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
DEC. 29, 1904

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

299 HURLEY AVENUE

10f. Zip Code

20850

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SALES

16b. Kind of Business/Industry

SHOES

17. Father's Name (First, Middle, Last)

"UNKNOWN" WEISSMAN

18. Mother's Name (First, Middle, Maiden Summa)

ROSE "UNKNOWN"

19a. Informant's Name/Relationship (Type, Print)

NORMAN WEIL/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8252 LOCHINVER LANE, POTOMAC, MARYLAND 20852

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

KING DAVID MEMORIAL GDNS 8/4/97

Date

20c. Location - City or Town, State

FALLS CHURCH, VIRGINIA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.

1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC ARREST

Due to (or as a consequence of):

b. BRADYCARDIA

Due to (or as a consequence of):

c. MYOCARDIAL FIBROSIS

Due to (or as a consequence of):

d. CORONARY ARTERY DISEASE

Approximate Interval Between Onset and Death

-0-

WEEKS

MONTHS

YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTHYROIDISM, DEMENCIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Peter S. Birk, M.D.

29c. License number

D15060

29d. Date signed (Month, Day, Year)

August 3, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DR. PETER S. BIRK, MD 10829 GEORGIA AVENUE, SILVER SPRING, MARYLAND 20902-4750

31. Date filed (Month, Day, Year)

AUG 05 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25106

Item:5 per FH G-751 9/10/97 dh

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) IRENE LOIS WEIDLER | | | | 2. Date of Death Month AUGUST 3 Day 1997 Year | | 3. Time of Death 12:08 AM | |
| | 4a. Facility Name (If not institution, give street and number) 1007 PARRS RIDGE DRIVE | | | | 4b. City, Town, or Location of Death SPENCERVILLE | | 4c. County of Death MONTGOMERY | |
| Funeral Director | 5. Social Security Number 120-16-2687 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 72 Yrs. | | 8. Date of Birth (Month, Day, Year) JAN. 29, 1925 | |
| | 9. Birthplace (State or Foreign Country) NEW YORK | | Usual Residence of Decedent | | 10a. State MARYLAND | | 10b. County MONTGOMERY | |
| To Be Completed by Funeral Director | 10c. City, Town or Location SPENCERVILLE | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 1007 PARRS RIDGE DRIVE | | 10f. Zip Code 20868 | |
| | 10g. Citizen of What Country? UNITED STATES | | 11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No, if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PHOTOGRAPHER-ARTIST | | 16b. Kind of Business/Industry PHOTOGRAPHY INDUSTRY | |
| | 17. Father's Name (First, Middle, Last) DAVID EPSTEIN | | 18. Mother's Name (First, Middle, Maiden Surname) CAROLYN HOFFMAN | | 19a. Informant's Name/Relationship (Type, Print) MILTON J. WEIDLER/HUSBAND | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1107 PARRS RIDGE DRIVE, SPENCERVILLE, MARYLAND 20868 | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MOUNT COMFORT CREMATORY | | 20c. Date 8/4/97 | | 20d. Location - City or Town, State ALEXANDRIA, VIRGINIA | |
| | 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 | | 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Metastatic Lung Cancer | | Approximate Interval Between Onset and Death 2 years | |
| | 23b. Part II: Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23c. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | |
| | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier  | | 29c. License number D29675 | | 29d. Date signed (Month, Day, Year) AUGUST 4, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) RALPH BOLLIA, MD 9707 MEDICAL CENTER DRIVE, ROCKVILLE, MARYLAND 20852 | | 31. Data filed (Month, Day, Year) AUG 05 1997 | | 32. Registrar's Signature  | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

20

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25107

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Harry Franklin Weber | | | | 2. Date of Death Month July Day 30 Year 1997 | | 3. Time of Death 12:45 PM | |
| | 4a. Facility Name (If not institution, give street and number) Layhill Center | | | | 4b. City, Town, or Location of Death Silver Spring | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 405-32-2699 | | 6. Sex 1 M 2 F | | 7. Age (In yrs. last birthday) 98 Yrs. | | 8. Date of Birth (Month, Day, Year) July 24, 1899 | |
| | 9. Birthplace (State or Foreign Country) Illinois | | 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Wheaton | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 Yes 2 No | | 10e. Street and Number 1517 Arbor View Road | | 10f. Zip Code 20902 | | 10g. Citizen of What Country? United States | |
| | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collage (1-4or 5+) 5+ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) National Safety Administration | | 16b. Kind of Business/Industry Government | | | |
| | 17. Father's Name (First, Middle, Last) John F. Weber | | | | 18. Mother's Name (First, Middle, Maiden Surname) S. Emma Ebersole | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Ronald F. Weber | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1517 Arbor View Road, Wheaton, Md. 20902 | | | |
| | 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Memorial Park | | 20c. Location - City or Town, State Aug. 1, 1997 Rockville, Md. | | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | |
| To Be Completed by Physician/Medical Examiner | 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, Md. 20904 | | | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. RENAL FAILURE & ACUTE TERM ARTERIOCLAR NEPHROSCLEROSIS A.S.C.V.D. | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown | | | | 24a. Was an autopsy performed? 1 Yes 2 No | | | |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No | | | | 25. Was case referred to medical examiner? 1 Yes 2 No | | | |
| | 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | | |
| To Be Completed by Physician/Medical Examiner | 28a. Date of Injury (Month, Day, Year) Aug 5 1997 | | | | 28b. Time of Injury M | | 28c. Injury at Work? 1 Yes 2 No | |
| | 28d. Describe how injury occurred | | | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| To Be Completed by Physician/Medical Examiner | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | |
| | 29b. Signature and title of certifier <i>[Signature]</i> MD | | | | 29c. License number D06406 | | 29d. Date signed (Month, Day, Year) JULY 30, 1997 | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DONALD R. LEWIS MD RT108 OLNEY, MD 20832 | | | | 31. Date filed (Month, Day, Year) AUG 5 1997 | | | |
| | 32. Registrar's Signature <i>[Signature]</i> | | | | 33. State Registrar State Registrar | | | |

Baltimore, Maryland 21215-0020

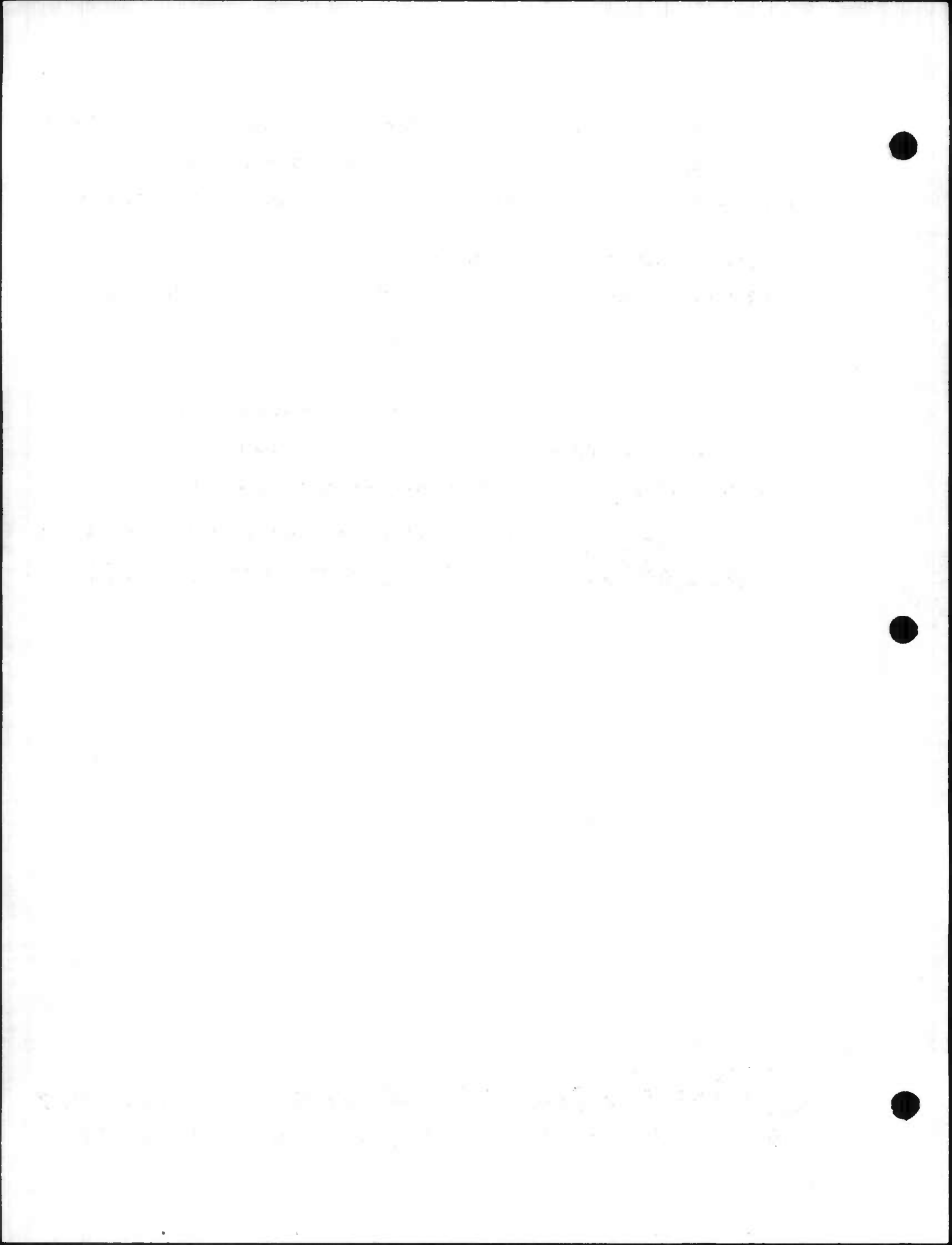
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

30



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25108

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SIDNEY WASSER

2. Date of Death

Month Day Year
JULY 26, 1997

3. Time of Death

11:00PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

1108 WOODSIDE PARKWAY

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

5. Social Security Number

326-01-9187

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

FEB 19, 1909

9. Birthplace (State or Foreign Country)

POLAND

Usual Residence of Decedent

10a. State

CA

10b. County

LOS ANGELES

10c. City, Town or Location

BEVERLY HILLS

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

430 SOUTH PALM DRIVE

10f. Zip Code

90212

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

TAILOR

16b. Kind of Business/Industry

MANUFACTURING

17. Father's Name (First, Middle, Last)

JOSEPH WASSER

18. Mother's Name (First, Middle, Maiden Surname)

unknown

19a. Informant's Name/Relationship (Type, Print)

JUDITH KERMAIER/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1108 WOODSIDE PARKWAY, SILVER SPRING, MD 20910

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

HOME OF PEACE CEMETERY

Date

7/27/97

20c. Location - City or Town, State

LOS ANGELES, CALIFORNIA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.

1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. BRAIN TUMOR

Due to (or as a consequence of):

3 MONTHS

b. RENAL CELL CARCINOMA

Due to (or as a consequence of):

3 YEARS

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

8 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D19170

29d. Date signed (Month, Day, Year)

JULY 29, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALAN I. KERMAIER, MD 10313 GEORGIA AVENUE, SILVER SPRING, MARYLAND 20902

31. Date filed (Month, Day, Year)

AUG 05 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25109
Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|---|-------------------------------|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ELEANOR Elizabeth WARNER | | | | 2. Date of Death Month Day Year AUGUST 4, 1997 | | 3. Time of Death 2:45 AM | |
| | 4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital | | | | 4b. City, Town, or Location of Death Frederick | | 4c. County of Death Frederick | |
| Funeral Director | 5. Social Security Number 219-12-1305 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 86 Yrs. | | 8. Date of Birth (Month, Day, Year) Feb 25, 1911 | |
| | 9. Birthplace (State or Foreign Country) Ohio | | 10a. State Maryland | | 10b. County Frederick | | 10c. City, Town or Location Union Bridge | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 11018 Green Valley Rd. | | 10f. Zip Code 21791 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Factory Worker | | 16b. Kind of Business/Industry Rubber Co. | | | |
| | 17. Father's Name (First, Middle, Last) Thomas Smith | | | | 18. Mother's Name (First, Middle, Maiden Surname) Opal E. Palmer | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Elizabeth Snyder/daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11010 Green Valley Rd. Union Bridge, Md. 21791 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Johnsville Methodist Cem. | | Date Aug 7, 1997 | | 20c. Location - City or Town, State Union Bridge, Md. | |
| | 21. Signature of Funeral Service Licensee Catherine O. Hartzler | | 22. Name and Address of Facility Hartzler Funeral Home Union Bridge, Md. 21791 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Myocardial infarction Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | Approximate Interval Between Onset and Death 48 hrs. | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Poly myalgia rheumatica | | | | | | | |
| Physician /Medical Examiner | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28d. Describe how injury occurred | | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier Austin Pearce | | | | 29c. License number D09689 | | 29d. Date signed (Month, Day, Year) 8/4/97 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Austin A. Pearce, Jr. 300 W. 9th ST. Frederick, Md. 21701 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 06 1997 | | 32. Registrar's Signature John Davidson Randall | | | | | | |

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25110

| | | | | | | | | |
|--|--|---|--|---------------------------------------|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Joseph Everett Wenk, Sr. | | | | 2. Date of Death Month August Day 08 , Year 1997 | | 3. Time of Death 1:03AM | |
| | 4a. Facility Name (If not institution, give street and number) Physicians Memorial Hospital | | | | 4b. City, Town, or Location of Death La Plata | | 4c. County of Death Charles | |
| Funeral Director | 5. Social Security Number 213-54-5120 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 48 Yrs. | | 8. Date of Birth (Month, Day, Year) May 9, 1949 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Charles | | 10c. City, Town or Location Indian Head | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 4390 Strauss Ave. | | 10f. Zip Code 20640 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collage (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrician | | 16b. Kind of Business/Industry US Government | | | |
| | 17. Father's Name (First, Middle, Last) William T. Wenk Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname) Edna M. Wenk (Rice) | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Elizabeth Lee Matthews (sister) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 220 Judith Circle Yorktown, Virginia 23693 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Trinity Memorial Gardens | | 20c. Location - City or Town, State Waldorf, Maryland | | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Williams Funeral Home M00668 4270 Hawthorne Rd. Indian Head, Maryland 20640 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE PNEUMONIA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. CIRRHOSIS OF LIVER Due to (or as a consequence of): c. UPPER GASTROINTESTINAL BLEED Due to (or as a consequence of): d. | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. CIRRHOSIS OF LIVER UPPER GASTROINTESTINAL BLEED | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number D-28281 | | 29d. Date signed (Month, Day, Year) 08/09/97 | | |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) Nelson Benjers, MD Suite 102, 8926 Woodyard Road, Clinton, Maryland 20735 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 11 1997 | | 32. Registrar's Signature | | | | | | |

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State of Maryland / Department of Health and Mental Hygiene 97 25111

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|---|--|--|--------------------------------|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) David Patrick Walsh | | | | 2. Date of Death Month August Day 5 Year 1997 | | 3. Time of Death 9:30 Pm | |
| | 4a. Facility Name (If not institution, give street and number) Charlotte Hall Veterans Home | | | | 4b. City, Town, or Location of Death Charlotte Hall | | 4c. County of Death St. Mary's | |
| Funeral Director | 5. Social Security Number 579-16-8098 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 76 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) May 13, 1921 | 9. Birthplace (State or Foreign Country) Washington, DC |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County St. Mary's | | 10c. City, Town or Location Charlotte Hall | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number 29449 Charlotte Hall Road | | | | 10f. Zip Code 20622 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1941-1945 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Patent & Industrial Design | | 16b. Kind of Business/Industry Industrial | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) David Patrick Walsh | | | | 18. Mother's Name (First, Middle, Maiden Surname) Margaret Estelle Heard Walsh | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Marcus Brookbank | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29449 Charlotte Hall Rd. Charlotte Hall, MD 20622 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cem. 8/12 Cheltenham, MD | | 20c. Location - City or Town, State | | | |
| | 21. Signature of Funeral Service Licensee M00174 <i>[Signature]</i> | | 22. Name and Address of Facility AREHART - ECHOLS FUNERAL HOME, INC. P.O. BOX 517 LA PLATA, MD | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. METASTATIC CARCINOMA Due to (or as a consequence of): e. _____ Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death FEW MONTHS |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PROSTATE CANCER DEAFNESS DEPRESSION | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| State Registrar | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier <i>[Signature]</i> ATTENDING | | 29c. License number D-44436 | | 29d. Date signed (Month, Day, Year) August 06 1997 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASHVINKUMAR J PATEL 603 POSTOFFICE RD #207 WALDORF MD 20602 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 11 1997 | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25112

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jesse Bates Walls, Sr.

2. Date of Death
Month Day Year

August 2, 1997 8:45 p.m.

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

217 Princess Ann Drive (At Home)

4b. City, Town, or Location of Death

Chestertown

4c. County of Death

Queen Annes

5. Social Security Number

217-36-0375

6. Sex

XXM 2 F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

July 31, 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Queen Annes

10c. City, Town or Location

Chestertown

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

217 Princess Ann Drive

10f. Zip Code

21620

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 Yes 2 No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Agricultural Farmer

16b. Kind of Business/Industry

Agriculture

17. Father's Name (First, Middle, Last)

Samuel McCosh Walls

18. Mother's Name (First, Middle, Maiden Surname)

Mary Elizabeth Slaughter

19a. Informant's Name/Relationship (Type, Print)

Ann S. Walls/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

217 Princess Ann Drive, Chestertown, Maryland 21620

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Crumpton Cemetery/August 5, 1997 Crumpton, Maryland

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Birk J. Helfenbein

22. Name and Address of Facility

Fellows, Helfenbein & Newnam Funeral Home, P.A.
130 Speer Road, Chestertown, Maryland 21620

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)a. Brochogenic Carcinoma
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

4 years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Giant Cell Carcinoma of Pelvis

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy
performed?

1 Yes 2 No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1 Yes 2 No

25. Was case referred to medical
examiner?
1 Yes 2 No

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home

5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending
2 Accident 6 investigation
3 Suicide 6 Could not be
4 Homicide 6 determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 Yes 2 No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

H. H. Wun, M.D.

29c. License number

D21313

29d. Date signed (Month, Day, Year)

8/4/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KIN K. WUN, 223 High St., Chestertown, MD 21620

31. Date filed (Month, Day, Year)

AUG 4 '97

32. Registrar's Signature

Julia Davidson-Randall

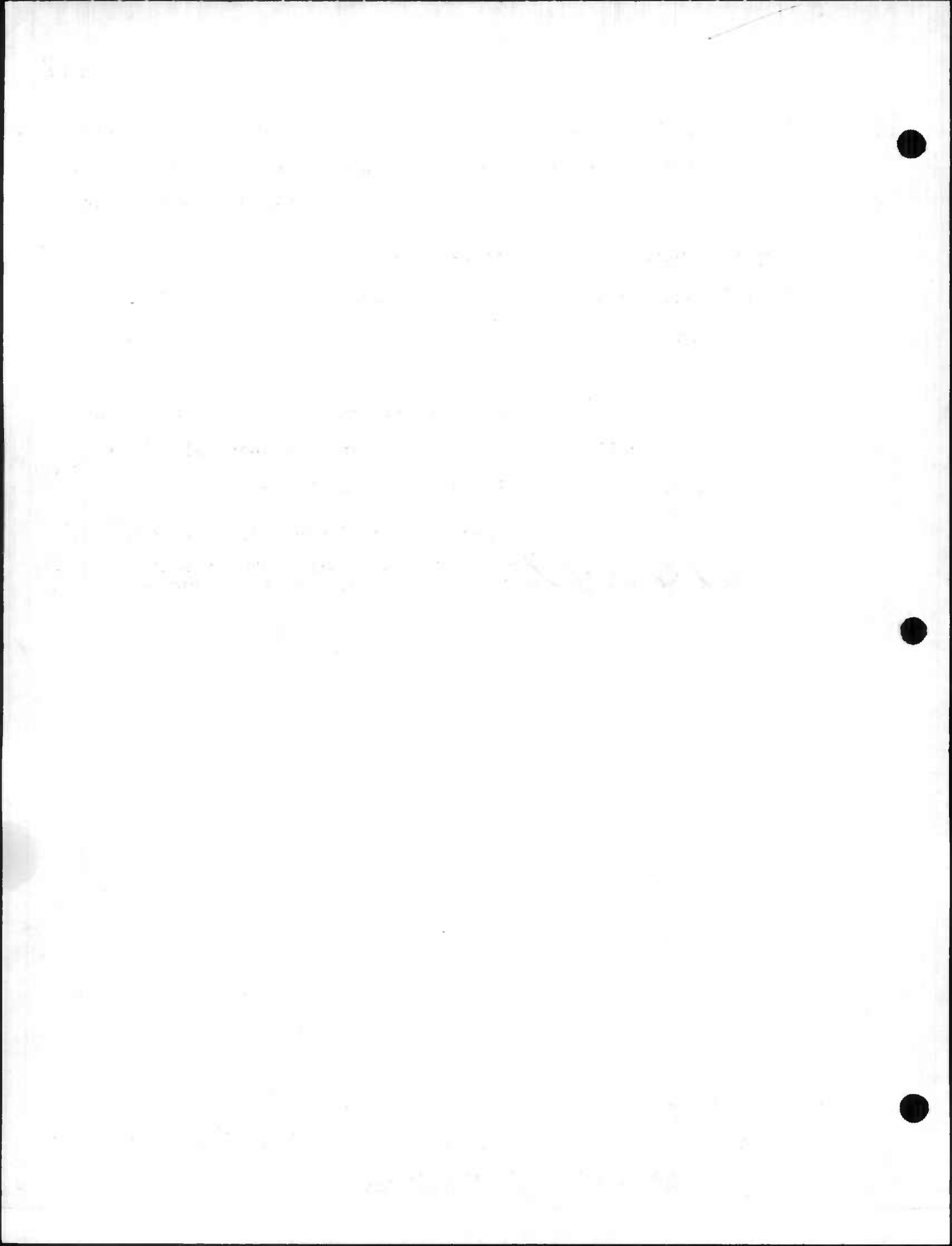
State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25113

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | |
|---|--|--|---|--|---|--|---|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Lois Marie Weber | | | | 2. Date of Death Month August Day 7 Year 1997 | | | | 3. Time of Death 6:30 a.m. | | | | | |
| | 4e. Facility Name (If not institution, give street and number) 210 Rolling Road (At Home) | | | | 4b. City, Town, or Location of Death Chestertown | | | | 4c. County of Death Kent | | | | | |
| Funeral Director | 5. Social Security Number 212-26-8826 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 68 Yrs. | | 8. Date of Birth (Month, Day, Year) February 19, 1929 | | 9. Birthplace (State or Foreign Country) Maryland | | | | | |
| | Usual Residence of Decedent | | | | 10a. State Maryland | | | | 10b. County Kent | | 10c. City, Town or Location Chestertown | | | |
| To Be Completed by Funeral Director | 10e. Street and Number 210 Rolling Road | | | | 10f. Zip Code 21620 | | | | 10g. Citizen of What Country? U.S.A. | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) College | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Day Care Employee | | | | 16b. Kind of Business/Industry Day Care | | | | | |
| | 17. Father's Name (First, Middle, Last) Charles Theodore Bathgate | | | | 18. Mother's Name (First, Middle, Maiden Surname) Ruth Irene McCurtin | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Joseph L. Weber, Jr. | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 210 Rolling Road, Chestertown, Maryland 21620 | | | | | | | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Cremation Center, LLC/Stevensville, Maryland | | | | 20c. Location - City or Town, State August 8, 1997 | | | | | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee Kirk J. Helfenbein | | | | 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620 | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. PTEROPHYTIC CIRCUMSTANCES Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death 6 mos | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | |
| | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| | 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day Year) | | | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier J. C. Davidson-Randall | | | | 29c. License number 12-13824 | | | | 29d. Date signed (Month, Day, Year) 8-7-97 | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) | | | | | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) AUG 7 '97 | | | | 32. Registrar's Signature J. C. Davidson-Randall | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

97 25114

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Dorothy B. Baublitz | | | | 2. DATE OF DEATH MONTH DAY YEAR 08 12 97 | | | | 3. TIME OF DEATH 7:40 a.m. | |
| 4. SOCIAL SECURITY NUMBER 219-22-0970 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 79 YRS. | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year) Dec 29, 1917 | |
| 9a. FACILITY NAME (If not institution, give street and number) Caton Manor-Genesis ElderCare | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | | | 9c. COUNTY OF DEATH Baltimore City | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore City | | 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 3330 Wilkins Avenue | | | | 10f. ZIP CODE 21229 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | | | 16b. KIND OF BUSINESS/INDUSTRY Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last) Charles Leroy Baublitz | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Ellen Crawford | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mary Gettier/daughter | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4223 Thayer Court, Baltimore, Maryland 21225 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | DATE | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald S. Wade, Director | | | | 22. NAME AND ADDRESS OF FACILITY State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. suspected cardiac arrhythmia DUE TO (OR AS A CONSEQUENCE OF): b. suspected cardiac failure DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | Approximate interval Between Onset and Death couple minutes 24 hours | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. emphysema with partial left lung resection early 1990's | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER Jerry D. Skarbek, M.D. | | 29c. LICENSE NUMBER 029767 | | 29d. DATE SIGNED (Month, Day, Year) 08-12-97 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jerry D. Skarbek, M.D. 8418 Pasadena, Baltimore-Annapolis Blvd. Md. 21122 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) AUG 20 1997 | | | | 32. REGISTRAR'S SIGNATURE Julia K. Anderson | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25115
Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|--|---|--|---|--------------------------------|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Maryanne Blueford | | | | 2. Date of Death Month Day Year August 8 1997 | | 3. Time of Death 11:00A.M. | | | |
| | 4e. Facility Name (If not institution, give street and number) Johns Hopkins Bayview | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death Baltimore City | | | |
| Funeral Director | 5. Social Security Number 218-53-6291 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 43 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Nov. 14, 1953 | | 9. Birthplace (State or Foreign Country) unknown | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10e. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number 5505 Hopkins Bayview Drive | | | | 10f. Zip Code 21224 | | 10g. Citizen of What Country? U.S.A. | | | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown | | College (1-4or 5+) unknown | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unknown | | | 16b. Kind of Business/Industry unknown | | |
| | 17. Father's Name (First, Middle, Last) unknown | | | | 18. Mother's Name (First, Middle, Maiden Surname) unknown | | | | | |
| Physician /Medical Examiner | 19e. Informant's Name/Relationship (Type, Print) unknown | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unknown | | | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) in state | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) | | Date | | 20c. Location - City or Town, State | |
| | 21. Signature of Funeral Service Licensee Ronald S. Wade | | | | 22. Name and Address of Facility Ronald S. Wade, Director State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201 | | | | | |
| | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Sepsis Due to (or as a consequence of): b. Bilateral lower Extremity Gangrene Due to (or as a consequence of): c. Pericardial Tamponade Due to (or as a consequence of): d. | | | | Approximate Interval Between Onset and Death 8/4-8/8/97 8/4-8/8/97 Unknown | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Primary Metastatic Adenocarcinoma of Lung AIDS | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown 24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28e. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. | | 29b. Signature and title of certifier Shalini Tewari MD (Resident) | | | | | 29c. License number 960118 | | 29d. Date signed (Month, Day, Year) August 8, 1997 |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shalini Tewari M.D. Johns Hopkins Bayview / 4940 Eastern Avenue | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 20 1997 | | 32. Registrar's Signature Julia Davidson-Randall | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25116

| | | | | | | | | |
|--|---|---|--|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MARGARET Barker | | | | 2. Date of Death Month Day Year AUGUST 14 1997 | | 3. Time of Death 9:05 pm | |
| | 4a. Facility Name (If not institution, give street and number) LIBERTY MEDICAL CENTER | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 214-24-3392 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 81 Yrs. | | 8. Date of Birth (Month, Day, Year) 06/26/1916 | |
| | 9. Birthplace (State or Foreign Country) MD | | 10a. State MD | | 10b. County BALTIMORE | | 10c. City, Town or Location NOTTINGHAM | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 9000 LODI ROAD | | 10f. Zip Code 21236 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CLERK | | 16b. Kind of Business/Industry RETAIL SALES | | | | |
| 17. Father's Name (First, Middle, Last) GEORGE BROCK MEYER | | | | 18. Mother's Name (First, Middle, Maiden Surname) KATHERINE RITTER | | | | |
| 19a. Informant's Name/Relationship (Type, Print) DAVID BARKER/ SON | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9000 LODI ROAD BALTIMORE, MD 21236 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) SACRED HEART OF JESUS CEM | | 20c. Location - City or Town, State 8/18/97 DUNDALK, MD. | | | | |
| 21. Signature of Funeral Service Licensee Philly Harris | | 22. Name and Address of Facility BRADLEY-ASHTON FUNERAL HOME, INC. 2134 WILLOW SPRING RD. DUNDALK, MD 21222 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Cerebrovascular accident Due to (or as a consequence of): b. carotid stenosis Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | Approximate Interval Between Onset and Death 8-12-97 | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Terance L. Lamb | | 29c. Licensa number D37203 | | 29d. Date signed (Month, Day, Year) AUGUST 14th 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) TERANCE L. LAMB Liberty Medical Center. Baltimore md 21215 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 20 1997 | | 32. Registrar's Signature Julia Davidson-Randall | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permt. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: The death certificate has been signed by the attending physician and complatly filled in by the funeral director; page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

3

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 25117**
Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--------------------------|---|--|---|--|---|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Rebecca Brown | | | | 2. Date of Death Month 08 Day 18 Year 97 | | 3. Time of Death 10:30AM | |
| | 4a. Facility Name (If not institution, give street and number) 3210 Lake Ave | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death NA | |
| Funeral Director | 5. Social Security Number 239-6789 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 79 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) May 20, 1918 | 9. Birthplace (State or Foreign Country) N.C. |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | 10b. County NA | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number 2209 W. Lexington Street | | | | 10f. Zip Code 21229 | | 10g. Citizen of What Country? U.S.A | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th grade College (1-4 or 5+) NA | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housekeeper | | 16b. Kind of Business/Industry Hospital | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) William Hester | | | | 18. Mother's Name (First, Middle, Maiden Surname) Emma Carter | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Helen Warren Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2209 W. Lexington St. Balto Md. 21229 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery | | 20c. Location - City or Town, State 8-22-97 Balto. Md | | 20d. Date | |
| | 21. Signature of Funeral Service Licensee Thyng B Harris | | 22. Name and Address of Facility 4300 Wabash Avenue Balto, Md 21205 | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myocardial Infarct Due to (or as a consequence of): DIABETES MELLITUS YRS ASCVD YRS | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hyperthyroidism | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | 28d. Describe how injury occurred | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| State Registrar | 29b. Signature and title of certifier Richard F. Tyson M.D. | | | | 29c. License number 10268 | | 29d. Date signed (Month, Day, Year) 08-19-97 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard F. Tyson M.D. 936 West North Ave. Baltimore, Md. 21217 | | | | | | | |
| | 31. Date filed (Month, Day, Year) AUG 20 1997 | | 32. Registrar's Signature Julia Davidson-Randall | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 24 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural" for item 23a or 23a-f show any injury or other traumatic event. Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25118

| | | | | | | | | |
|--|--|---|--|---|---|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) SAUNDRA E. BANKS | | | | 2. Date of Death Month Day Year AUGUST 17, 1997 | | 3. Time of Death 15:20 p | |
| | 4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKIN HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE CITY | | 4c. County of Death n/a | |
| Funeral Director | 5. Social Security Number 218-44-9547 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 49 Yrs. | | 8. Date of Birth (Month, Day, Year) MAY 1, 1948 | |
| | 9. Birthplace (State or Foreign Country) MARYLAND | | 10a. State MD | | 10b. County n/a | | 10c. City, Town or Location BALTIMORE | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 715 N. CARROLLTON AVENUE | | 10f. Zip Code 21217 | | 10g. Citizen of What Country? UNITED STATES | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 th College (1-4 or 5+) 4 years | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CLERK | | 16b. Kind of Business/Industry CIRCUIT COURT of BALTIMORE CITY | | | | |
| 17. Father's Name (First, Middle, Last) HORACE N. SMITH | | 18. Mother's Name (First, Middle, Maiden Surname) EVA COOK SMITH | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) EVA P. SMITH-sister | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 715 N. CARROLLTON AVE., BALTIMORE, MD # 17 | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) WOODLAWN CEMETERY | | 20c. Location - City or Town, State 8-21-97 BALTIMORE co, MD | | | | |
| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility MARCH FH. 4300 WABASH AVENUE | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. HEART TRANSPLANT REJECTION Due to (or as a consequence of): b. HEART TRANSPLANT Due to (or as a consequence of): c. VIRAL MYOCARDITIS Due to (or as a consequence of): d. | | Approximate Interval Between Onset and Death 6 WEEKS 6 WEEKS 1 YEAR | | | | | | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier WS [Signature], MD | | 29c. License number RES-000 | | 29d. Date signed (Month, Day, Year) AUGUST 18, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM QUEALE 600 NORTH WOLFE STREET BALTIMORE, MARYLAND 21287-9106 | | 31. Date filed (Month, Day, Year) AUG 20 1997 | | 32. Registrar's Signature | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25119

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Eva Alberta Boyd

2. Date of Death

Month
AUGUST

Day

18

Year

1997

3. Time of Death

13:30

pm

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

na

Funeral
Director

5. Social Security Number

212-50-6744

6. Sex

1 ☐ M2 ☒ F

7. Age (In yrs. last birthday)

48

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

NOV. 9, 1948

9. Birthplace (State or Foreign Country)

BALTIMORE, MD

Usual Residence of Decedent

10a. State

MD

10b. County

na

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

4104 EDMONDSON AVENUE

10f. Zip Code

21229

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

OPERATOR

16b. Kind of Business/Industry

A.T. & T.

17. Father's Name (First, Middle, Last)

ALBERT WINGATE

18. Mother's Name (First, Middle, Maiden Surname)

EVA GREENE

19a. Informant's Name/Relationship (Type, Print)

MICHAWN FOSTER- Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4104 EDMONDSON AVENUE BALTIMORE, MD #29

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

WOODLAWN CEMETERY

Date

8-23-97

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

Glynn B. Ham

22. Name and Address of Facility

MARCH FH.-4300 WABASH AVENUE, BALTO, MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Extensive metastases to the lungs

Due to (or as a consequence of):

7 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Breast Cancer

Due to (or as a consequence of):

3 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Mark Milton - Intern

29c. License number

Res-000

29d. Date signed (Month, Day, Year)

August 18, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Mark Allen Milton Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore, MD 21287

31. Date filed (Month, Day, Year)

AUG 20 1997

32. Registrar's Signature

John F. Anderson

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked "other," items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

87 25120

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Elsie A. Barnes

2. Date of Death

Month

Day

Year

AUGUST 17 1997

3. Time of Death

2:25 am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death

GLENBURNIE

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

215-07-3448

6. Sex

☐ M☒ F

7. Age (In yrs. last birthday)

78

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Dec. 6, 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Pasadena

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

8146 Bodkin Ave

10f. Zip Code

21122

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Harry Wenger

18. Mother's Name (First, Middle, Maiden Surname)

Amelia Ledley

19a. Informant's Name/Relationship (Type, Print)

Richard F. Barnes, Sr. (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8146 Bodkin Ave, Pasadena, Md. 21122

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Glen Haven Memorial Pk.

Date

Aug. 20

20c. Location - City or Town, State

Glen Burnie, Md.

21. Signature of Funeral Service Licensee

John F. Collins

22. Name and Address of Facility

McCully-Polyniak Funeral Home of Pasadena

3204 Mountain Road, Pasadena, Md. 21122

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Non Small cell lung Cancer

Due to (or as a consequence of):

b.

Tobacco abuse

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

1 yr.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Smoking 5 cigs

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☒ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Pending investigation☐ Accident☐ Suicide☐ Homicide☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John Davidson, Randall

29c. License number

D 42219

29d. Date signed (Month, Day, Year)

8/17/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KOTA, I. 4306 HEEFLEN CT, RANDALL TOWN, MD 21133

31. Date filed (Month, Day, Year)

AUG 20 1997

32. Registrar's Signature

John Davidson, Randall

State
Registrar

ELSIE BARNES

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

REVISION of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25121

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) VERNON H. BECKER | | | | 2. Date of Death Month AUG. Day 11 Year 1997 | | 3. Time of Death 9:00 P.M. | |
| | 4a. Facility Name (If not institution, give street and number) ANNAPOLIS NURSING & REHAB. CENTER | | | | 4b. City, Town, or Location of Death ANNAPOLIS | | 4c. County of Death A.A.CO. | |
| Funeral Director | 5. Social Security Number 216-01-9601 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 87 Yrs. | | 8. Date of Birth (Month, Day, Year) FEB. 10, 1910 | |
| | 9. Birthplace (State or Foreign Country) MD. | | 10a. State MD. | | 10b. County A.A.CO. | | 10c. City, Town or Location ANNAPOLIS | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 1270 PINE HILL DR. | | 10f. Zip Code 21401 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SUPERVISER | | 16b. Kind of Business/Industry WESTERN ELEC. | | | |
| | 17. Father's Name (First, Middle, Last) JOHN F. W. BECKER | | | | 18. Mother's Name (First, Middle, Maiden Surname) ANNA BADEL | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) RONALD BECKER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1270 PINE HILL DR. ANNAPOLIS, MD. 21401 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) OAKLAWN CEM. | | 20c. Location - City or Town, State BALTO.CO. MD. | | 20d. Date AUG 13, 1997 | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee Thomas J. Alford Jr. | | | | 22. Name and Address of Facility HOFFMANN-SKALDA F.H. 3218 HUDSON ST. BALTO. MD. 21204 | | | |
| | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Stroke</u> Due to (or as a consequence of): b. <u>Brain</u> Due to (or as a consequence of): c. <u>Brain</u> Due to (or as a consequence of): d. <u>Brain</u> Due to (or as a consequence of): | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimer's Disease | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier Richard L. Hochman, MD | | 29c. License number 1705192 | | 29d. Date signed (Month, Day, Year) 8/12/97 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard L. Hochman, MD 1833 A Forest Dr, Annapolis, Md 21401 | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 31. Date filed (Month, Day, Year) AUG 20 1997 | | 32. Registrar's Signature Julia Davidson-Randall | | | | | |
| | 33. Date of Death (Month, Day, Year) AUG 11, 1997 | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

57 25122

| | | | | | | | | | | | |
|---|---|---|---|---|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ELIZABETH BONHAM | | | | | 2. Date of Death Month Day Year AUGUST 15, 1997 | | | 3. Time of Death 2015 | | |
| | 4a. Facility Name (If not institution, give street and number) ST. AGNES HOSPITAL | | | | | 4b. City, Town, or Location of Death BALTIMORE | | | 4c. County of Death N/A | | |
| Funeral Director | 5. Social Security Number 218-72-7217 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 78 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) DEC. 1, 1918 | | 9. Birthplace (State or Foreign Country) BENTREE, W.VA. | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD. | | 10b. County BALTIMORE | | 10c. City, Town or Location CATONSVILLE | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number 5743 EDMONDSON AVE. | | | | 10f. Zip Code 21228 | | 10g. Citizen of What Country? U.S.A. | | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 Collega (1-4 or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER | | | 16b. Kind of Business/Industry OWN HOME | | | | |
| | 17. Father's Name (First, Middle, Last) PHILIP R. MOORE | | | | | 18. Mother's Name (First, Middle, Maiden Surname) ANNA SMITH | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) FRANCES L. PENCE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 775 FAYETTEVILLE, W.VA 25840 | | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) VICKERS CEM. | | Date AUG. 21 1997 | | 20c. Location - City or Town, State PINCH, W.VA. | | | | |
| | 21. Signature of Funeral Service Licensee <i>Thomas J. Skarda Jr.</i> | | | | 22. Name and Address of Facility SKARDA FH. 2829 HUDSON ST. BALTIMORE, MD. 21224 | | | | | | |
| | 23a. Pert 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | Approximate Interval Between Onset and Death |
| | Immediate Cause (Final disease or condition resulting in death) e. Acute myocardial infarction Due to (or as a consequence of): b. ASCVD Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ | | | | | | | | | | 2 hours years |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. chronic obstructive lung disease diabetes mellitus | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DCA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier <i>Jerome I. Snyder MD</i> | | | | | 29c. License number D 22648 | | | 29d. Date signed (Month, Day, Year) August 15, 1997 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jerome I Snyder MD. 900 S. CATON AVE BALTIMORE MARYLAND 21229 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 20 1997 | | 32. Registrar's Signature <i>John Davidson</i> | | | | | | | | | |

NAME: ELIZABETH F. BONHAM
 Division of Vital Records, P.O. Box 68760,
 Baltimore, Maryland 21215-0020

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director
 To Be Completed by Physician/Medical Examiner

**Physician
/Medical
Examiner**

**State
Registrar**

B.K.S.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

JOSE DECARVALLO

State of Maryland / Department of Health and Mental Hygiene

Item 17 per FH Film G750 8-20-97 rja

Certificate of Death

Reg. No.

97 25123

| | | | | | | | | |
|---|---|--|---|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JOSE S DE CARVALHO | | | | 2. Date of Death Month Day Year AUG. 9, 1997 | | 3. Time of Death 0807 AM | |
| | 4a. Facility Name (If not institution, give street and number) 121 SOUTH CASTLE STREET | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 035-38-3860 | | 6. Sex 1 M 2 F | | 7. Age (In yrs. last birthday) 61 Yrs. | | 8. Date of Birth (Month, Day, Year) APRIL 1, 1936 | |
| | 9. Birthplace (State or Foreign Country) S. AFRICA | | 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location BALTO | |
| To Be Completed by Funeral Director | 10d. Inside City Limits X Yes 2 No | | 10e. Street and Number 121 S. CASTLE ST | | 10f. Zip Code 21231 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LONG SHOREMAN | | 16b. Kind of Business/Industry SHORE INDUSTRY | | 17. Father's Name (First, Middle, Last) DE CARVALHO | |
| | 18. Mother's Name (First, Middle, Maiden Surname) FRANCISCA VAZ DOSSANTES | | 19a. Informant's Name/Relationship (Type, Print) DIETRICK JONES | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 121 S. CASTLE ST BALTO, MD 21231 | | 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place) BALTIMORE CEM MOUNT ZION CEMETERY | | 20c. Location - City or Town, State 1997 BALTO, MD | | 21. Signature of Funeral Service Licensee <i>Patricia Betts</i> | | 22. Name and Address of Facility BETTS FUNERAL HOME 1129 N. CAROLINE ST BALTO., MD 21213 | |
| | 23a. Pertinent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown | | 24a. Was an autopsy performed? INSPECTION 1 Yes 2 No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 25. Was case referred to medical examiner? 1 Yes 2 No | | | |
| | 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | 27. Manner of Death X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | | |
| To Be Completed by Physician/Medical Examiner | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 Yes 2 No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier <i>Margarita Korell</i> | |
| To Be Completed by Physician/Medical Examiner | 29c. License number O.C.M.E | | 29d. Date signed (Month, Day, Year) AUG. 9, 1997 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | |
| | 31. Date filed (Month, Day, Year) AUG 20 1997 | | 32. Registrar's Signature <i>John Davidson-Randall</i> | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25124

GREGORY

CARTER

Items: 23 part I, 27 per ME0 G-751 9/15/97 re: Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|--|--|--|--|---|--|---|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) GREGORY R. CARTER SR. | | | 2. Date of Death Month Day Year AUGUST 16 1997 | | | 3. Time of Death 8:17 P.M. | | | |
| | 4a. Facility Name (If not institution, give street and number) 6422 BALTIMORE NATIONAL PIKE | | | 4b. City, Town, or Location of Death BALTIMORE | | | 4c. County of Death BALTIMORE | | | |
| Funeral Director | 5. Social Security Number 219-54-7419 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 47 Yrs. | | 8. Date of Birth (Month, Day, Year) Aug. 3 1950 | | 9. Birthplace (State or Foreign Country) MD | |
| | 10a. State MD | | | 10b. County BALTIMORE | | | 10c. City, Town or Location BALTIMORE | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10e. Street and Number 7413 REMOOR ROAD | | | 10f. Zip Code 21207 | | | 10g. Citizen of What Country? USA | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) NA | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) WAREHOUSE WORKER | | | 16b. Kind of Business/Industry ARAMARK | | | | |
| 17. Father's Name (First, Middle, Last) REUBEN D. CARTER | | | 18. Mother's Name (First, Middle, Maiden Surname) MARGARET J. CARTER | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) CATHERINE CARTER-WIFE | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7004 WODSILL CT. APT. 1B | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Lukes Cemetery | | | Date 8-20-97 | | 20c. Location - City or Town, State Baltimore, Md | | |
| 21. Signature of Funeral Service Licensee Julia R. March | | | 22. Name and Address of Facility MARCH FUNERAL HOME-WEST 4300 WABASH AVE. BALTIMORE, MD 21215 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. DIABETIC KETOACIDOSIS Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | Approximate Interval Between Onset and Death | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) HOTEL | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of injury (Month, Day Year) | | 28b. Time of injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier David R. Fowler | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) AUGUST 17, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) David R. Fowler 111 Penn Street, Baltimore, Maryland 21201 | | | 31. Date filed (Month, Day, Year) AUG 20 1997 | | | 32. Registrar's Signature Julia Davidson-Randall | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25125

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Charles F. Campbell

2. Date of Death
Month Day Year

Aug. 17, 1997

3. Time of Death

1:10pm

4a. Facility Name (If not institution, give street and number)

361 Marydell Road

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

216-09-0061

6. Sex

152 M 2 F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

Sept. 12, 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 X Yes 2 No

10e. Street and Number

361 Marydell Rd.

10f. Zip Code

21229

10g. Citizen of What Country?

United States

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 Yes 2 No
If Yes, Give
Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Gas Service Representative Gas Company

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

John W. Campbell

18. Mother's Name (First, Middle, Maiden Surname)

Nora Fleck

19a. Informant's Name/Relationship (Type, Print)

Mary A. Campbell, Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

361 Marydell Road Baltimore, Md. 21229

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Maryland Veterans

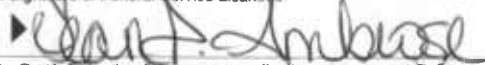
Date

8/21

20c. Location - City or Town, State

Garrison Forest, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Ambrose Funeral Home of Lansdowne
2719 Hammonds Ferry Road 2122723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Widely metastatic small cell carcinoma of lung 4 years
Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PROFOUND ORTHOSTATIC Hypotension;
Renal insufficiency, Severe Anemia,
EXTENSIVE BRAIN AND LIVER METASTASIS.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy
performed?

1 Yes 2 No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1 Yes 2 No

25. Was case referred to medical
examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending
2 Accident investigation
3 Suicide 6 Could not be
4 Homicide determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?
1 Yes 2 No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

 ATTENDING

29c. License number

D16200

29d. Date signed (Month, Day, Year)

AUGUST 19, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. N. M. MAKHRAM 720-CHAUDEN CHOICE LA, CATONSVILLE, MD 21228

31. Date filed (Month, Day, Year)

AUG 20 1997



Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
9028.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: This certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

97 25126

Reg. No.

| | | | | | | | | | | | |
|--|--|--|---|--|--|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Robert Lee Darneal | | | | | 2. Date of Death Month August Day 17 Year 1997 | | 3. Time of Death 8:05 PM | | | |
| | 4e. Facility Name (If not institution, give street and number) FREDERICK MEMORIAL HOSPITAL | | | | | 4b. City, Town, or Location of Death FREDERICK | | 4c. County of Death FREDERICK | | | |
| Funeral Director | 5. Social Security Number 567-09-3499 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 81 Yrs. | | 8. Date of Birth (Month, Day, Year) 07/02/1916 | | 9. Birthplace (State or Foreign Country) CA | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State MD | | | 10b. County CARROLL | | | 10c. City, Town or Location MT. AIRY | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 204 PARK AVE. | | | | | 10f. Zip Code 21771 | | | 10g. Citizen of What Country? U.S.A. | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+) | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) GEOPHYSICIST | | | 16b. Kind of Business/Industry FEDERAL GOVERNMENT | | | |
| 17. Father's Name (First, Middle, Last) LEE DARNEAL | | | | | 18. Mother's Name (First, Middle, Maiden Surname) MILDRED AMY ROBERTSON | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) BARBARA DARNEAL/ WIFE | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 187, MT. AIRY, MD 21771 | | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) CHESAPEAKE CREMATORY | | | Date 8/19/97 | | 20c. Location - City or Town, State BELTSVILLE, MD | | | |
| 21. Signature of Funeral Service Licensee  | | | | | 22. Name and Address of Facility STERLING ASHTON FUNERAL HOME, INC. 736 EDMONDSON AVE. CATONSVILLE, MD 21228 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="width: 35%;"> <p>a. congestive Heart Failure Due to (or as a consequence of):</p> <p>b. Coronary Artery Disease Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> </div> </div> | | | | | | | | | | Approximate Interval Between Onset and Death minutes Years | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pneumonia Cerebrovascular Disease | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier  | | | 29c. License number D0051610 | | 29d. Date signed (Month, Day, Year) 8-17-97 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1475 Toney Ave Suite 204 Frederick, MD 21702 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 20 1997 | | | 32. Registrar's Signature  | | | | | | | | |

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: This law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: This law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25127

| | | | | | | | | |
|--|---|--|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) William Francis Driscoll | | | | 2. Date of Death Month August Day 15 Year 1997 | | 3. Time of Death 3:22 am | |
| | 4a. Facility Name (If not Institution, give street and number) Gilchrist Center | | | | 4b. City, Town, or Location of Death Towson | | 4c. County of Death Baltimore Co. | |
| Funeral Director | 5. Social Security Number 012-02-7018 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 80 Yrs. | | 8. Date of Birth (Month, Day, Year) January 2, 1917 | |
| | Usual Residence of Decedent | | 9. Birthplace (State or Foreign Country) Massachusetts | | 10. State Maryland | | 10c. City, Town or Location Baltimore | |
| To Be Completed by Funeral Director | 10e. Street and Number 6401 Loch Raven Boulevard | | 10f. Zip Code 21239 | | 10g. Citizen of What Country? United States | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accountant | | 16b. Kind of Business/Industry Automotive Industry | | | |
| | 17. Father's Name (First, Middle, Last) Patrick J. Driscoll | | | | 18. Mother's Name (First, Middle, Maiden Surname) Helen M. Cadogan | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Marie H. Berger/ Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 128 Regent Drive BelAir, Maryland 21014 | | | |
| Physician /Medical Examiner | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery | | Date 8/18/97 | | 20c. Location - City or Town, State Baltimore, Maryland | |
| | 21. Signature of Funeral Service Licensee Brian A. Willem | | 22. Name and Address of Facility Leonard J. Ruck Funeral Home, Inc. 5305 Harford Road Baltimore, Maryland 21214 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Metastatic Pancreatic Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Artery Disease COPD | | | | | | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| State Registrar | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier | | 29c. License number D25205 | | 29d. Date signed (Month, Day, Year) August 19, 1997 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W.A.R. & G. BANC 6701 N. Charles St. Balto, MD 21205 | | | | | | | |
| | 31. Date filed (Month, Day, Year) AUG 20 1997 | | 32. Registrar's Signature | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

3. Time of Death
4:15 PMPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ERNEST T. FISHER SR.

2. Date of Death

Month Day Year
AUGUST 18, 1997

3. Time of Death

4:15 PM

4a. Facility Name (If not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

219-05-9991

6. Sex

☒ M ☐ F

7. Age (in yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug. 8, 1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7902 Landsdale Road

10f. Zip Code

21224

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
7th

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Stevedore

16b. Kind of Business/Industry

Local Steam Shop

17. Father's Name (First, Middle, Last)

John Fisher

18. Mother's Name (First, Middle, Maiden Surname)

Lillian Schluderberg

19a. Informant's Name/Relationship (Type, Print)

Dorothy Steinacker/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

938 Renfrew Street Baltimore Md. 21221

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Oak Lawn Cemetery 8/22/97

Date

20c. Location - City or Town, State

Baltimore Md.

21. Signature of Funeral Service Licensee

R. Terry Connelly

22. Name and Address of Facility

Connelly Funeral Home of Essex
300 Mace Ave. Baltimore MD. 2122123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

Cardiac arrest

Due to (or as a consequence of):

b.

Hypocalcemia

Due to (or as a consequence of):

c.

Metastatic cancer

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

minutes

48 hours

4 mos

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Richard M. Hirata, MD

29c. License number

D26585

29d. Date signed (Month, Day, Year)

Aug 17, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

RICHARD M. HIRATA, MD Ste 200W, 6569 N. Charles St, Baltimore 21204

31. Date filed (Month, Day, Year)

AUG 20 1997

32. Registrar's Signature

John J. Anderson

State
Registrar

Fisher, Ernest T SR.

Baltimore, Maryland 21215-0020

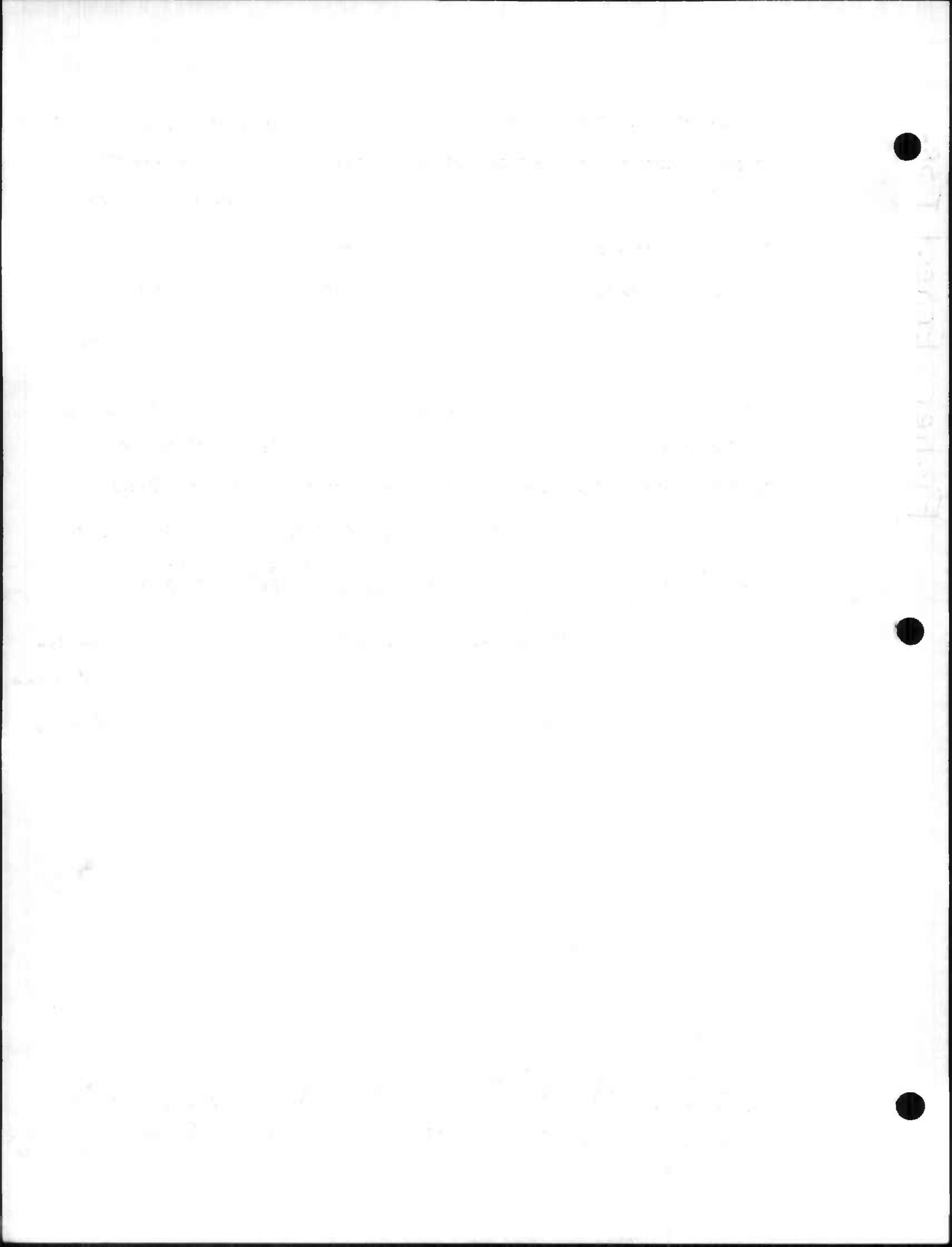
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25129

| | | | | | | | | |
|---|---|--|---|---|---|-----------------------------------|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) RUTH GOOD | | | | 2. Date of Death Month Day Year AUGUST 16 1997 | | 3. Time of Death 10:40 | |
| | 4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE CITY | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 180-34-8879 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 84 Yrs. | | 8. Date of Birth (Month, Day, Year) June 17, 1913 | |
| | 9. Birthplace (State or Foreign Country) Irwin, PA | | 10. Usual Residence of Decedent | | 10a. State MD | | 10b. County Anne Arundel Co. | |
| To Be Completed by Funeral Director | 10c. City, Town or Location Severna Park | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 43 West McKinsey Road | | 10f. Zip Code 21146 | |
| | 10g. Citizen of What Country? USA | | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| | 14. Race - American Indian, Black, White, etc. Specify: white | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Assistant Manager | | 16b. Kind of Business/Industry Clothing Industry | |
| | 17. Father's Name (First, Middle, Last) Joseph B. Peters | | 18. Mother's Name (First, Middle, Maiden Surname) Myrtle Ray | | 19a. Informant's Name/Relationship (Type, Print) Marilyn R. Jones/daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 759 Live Oak Drive Millersville, MD 21108 | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Penn-Lincoln Memorial Prk. | | 20c. Location - City or Town, State Aug 20, 1997 N. Huntington TWP., PA | | 21. Signature of Funeral Service Licensee <i>Robert Lewis</i> | |
| | 22. Name and Address of Facility Sterling Ashton Funeral Home 736 Edmondson Ave. Baltimore, MD 21228 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. INTRACRANIAL HEMORRHAGE Due to (or as a consequence of): b. CHRONIC ATRIAL FIBRILLATION Due to (or as a consequence of): c. HYPERTENSION Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 72 HOURS YEARS YEARS | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | |
| | 29b. Signature and title of certifier <i>Kristen R. Wagner, MD</i> | | 29c. License number RES-000 | | 29d. Date signed (Month, Day, Year) AUGUST 16, 1997 | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Kristen R. Wagner, MD, Johns Hopkins Hospital, Baltimore MD | |
| 31. Date filed (Month, Day, Year) AUG 20 1997 | | 32. Registrar's Signature <i>Julia Davidson-Randall</i> | | 33. Date of Death (Month, Day, Year) AUGUST 16 1997 | | 34. Time of Death 10:40 | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25130

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) JOSEPH F. GRZECOWIAK, JR.
2. Date of Death Month Day Year AUGUST 15, 1997
3. Time of Death 11:26am

Funeral
Director

4a. Facility Name (If not institution, give street and number) UNIVERSITY OF MARYLAND MEDICAL CENTER
4b. City, Town, or Location of Death BALTIMORE
4c. County of Death BALTIMORE CITY

5. Social Security Number 216-92-9055
6. Sex ☒ M ☐ F
7. Age (In yrs. last birthday) 34 Yrs.
8. Date of Birth (Month, Day, Year) APRIL 10, 1963
9. Birthplace (State or Foreign Country) MARYLAND

Usual Residence of Decedent

10a. State MD
10b. County CITY
10c. City, Town or Location BALTIMORE CITY
10d. Inside City Limits ☒ Yes ☐ No

10e. Street and Number 707 SOUTH ROBINSON STREET
10f. Zip Code 21224
10g. Citizen of What Country? U.S.A.

11. Marital Status
1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed ☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc.
Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) FOREMAN
16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BETHLEHEM STEEL
16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last) JOSEPH F. GRZECOWIAK, SR.
18. Mother's Name (First, Middle, Maiden Surname) DARRYLE THORNTON

19a. Informant's Name/Relationship (Type, Print) JOSEPH F. GRZECOWIAK, SR.
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 707 SOUTH ROBINSON STREET BALTIMORE, MD 21224

20a. Method of Disposition
1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place) GREEN MOUNT CEMETERY
Date 8/16
20c. Location - City or Town, State BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee Elizabeth Selinski
22. Name and Address of Facility LILLY & ZEILER, INC. FUNERAL HOME
1901 EASTERN AVENUE BALTIMORE, MARYLAND 21231

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) e. Cerebral Herniation
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { b. Hydrocephalus
Due to (or as a consequence of):
c. Chronic Meningitis
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?
1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?
1 ☒ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No
Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death
1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier Cheryl Bernstein MD
29c. License number AU4176435
29d. Date signed (Month, Day, Year) August 15, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Cheryl Bernstein University of Maryland Medical Center 22 South Greene Street Baltimore Maryland 21201

31. Date filed (Month, Day, Year) AUG 20 1997
32. Filing Signature

Baltimore, Maryland 21215-0020
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25131

Physician
/Medical
Examiner

1. Decedant's Name (First, Middle, Last)

Charles

Hiltz

2. Date of Death

Month

Day

Year

August 17

1997

3. Time of Death

1:30 PM

Funeral
Director

4a. Facility Name (If not Institution, give street and number)

Salisbury Center: Genesis ElderCare

4b. City, Town, or Location of Death

Salisbury, MD

4c. County of Death

Wicomico

5. Social Security Number

214-24-0554

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

68

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year

01/25/1929

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

DORCHESTER

10c. City, Town or Location

ELLIOTT ISLAND

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

2264 ELLIOTT ISLAND ROAD

10f. Zip Code

21869

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

OPERATING ENGINEER

16b. Kind of Business/Industry

LOCAL UNION 37

17. Father's Name (First, Middle, Last)

HENRY A. HILTZ

18. Mother's Name (First, Middle, Maiden Surname)

BESSIE M. DONAHO

19a. Informant's Name/Relationship (Type, Print)

EVA DEINLEIN/ DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3753 TIMAHOE CIR. BALTIMORE, MD 21236

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

CHESAPEAKE CREMATORY

Date

8/19/97

20c. Location - City or Town, State

BELTSVILLE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

BRADLEY-ASHTON FUNERAL HOME, INC.

2134 WILLOW SPRING ROAD DUNDALK, MD 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. End Stage Congestive Heart Failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

YEARS

YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. AND Renal Failure

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending Investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D39813

29d. Date signed (Month, Day, Year)

8/18/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1104 Healthway Dr., Salisbury, MD 21804

31. Date filed (Month, Day, Year)

AUG 20 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The attending physician that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate is signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

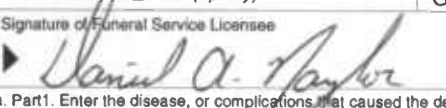
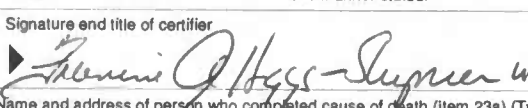

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

97 25132

Reg. No.

| | | | | | | | | | | | | | | | | |
|---|---|--|--|--|--|--|---|--|---|-------------------------|--|--------------------------------|-----------------|---|-----------------|----------|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Dorothy I. Wright - Haggerty | | | | 2. Date of Death Month Aug Day 12 Year 1997 | | 3. Time of Death 4:30am | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) Howard County General Hospital 5755 Cedar La | | | | 4b. City, Town, or Location of Death Columbia | | 4c. County of Death Howard | | | | | | | | | |
| Funeral Director | 5. Social Security Number 216-40-0036 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 54 Yrs. | | 8. Date of Birth (Month, Day, Year) Nov. 15 1942 | | | | | | | | | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Md. | | 10b. County n/a | | 10c. City, Town or Location Baltimore | | | | | | | | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 10e. Street and Number 3 West Ostend Street | | 10f. Zip Code 21230 | | | | | | | | | |
| | 10g. Citizen of What Country? USA | | | | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | | | | | | | | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: white | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collage (1-4or 5+) 0 | | | | | | | | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife/Domestic | | | | 16b. Kind of Business/Industry Home Owner | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last) Clarence Wright | | | | 18. Mother's Name (First, Middle, Maiden Surname) Agnes F. Mason | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Kam S. Haggerty (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2441 Bradenbaugh Road, White Hall, Md. 21161 | | | | | | | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Memorial Park | | 20c. Location - City or Town, State Aug. 15 1997 Glen Burnie, Md. | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility McCully-Polyniak Funeral Home of South Balto. 130 E. Fort Ave., Baltimore, Md. 21230 | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | |
| | <table border="0" style="width:100%;"> <tr> <td rowspan="4" style="vertical-align: middle; font-size: 3em;">{</td> <td>a. Renal failure</td> <td>Approximate Interval Between Onset and Death 14 days</td> </tr> <tr> <td>b. Obstructive uropathy</td> <td>7 months</td> </tr> <tr> <td>c. Metastatic Cervical Carcinoma</td> <td>7 months</td> </tr> <tr> <td>d. _____</td> <td></td> </tr> </table> | | | | | | | | { | a. Renal failure | Approximate Interval Between Onset and Death 14 days | b. Obstructive uropathy | 7 months | c. Metastatic Cervical Carcinoma | 7 months | d. _____ |
| { | a. Renal failure | Approximate Interval Between Onset and Death 14 days | | | | | | | | | | | | | | |
| | b. Obstructive uropathy | 7 months | | | | | | | | | | | | | | |
| | c. Metastatic Cervical Carcinoma | 7 months | | | | | | | | | | | | | | |
| | d. _____ | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pneumonia left lung Chronic obstructive pulmonary disease | | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | |
| 26. Place of Death (Check only one) 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how Injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier  29c. License number D28079 29d. Date signed (Month, Day, Year) Aug 12 1997 | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5082 Dorsey Hall Drive Ellicott City Maryland 21042 | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 20 1997 32. Registrar's Signature  | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
 To the Hospital/Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Physician/Medical Examiner

THOMAS E. HOWARD

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

THOMAS E. HOWARD

2. Date of Death

Month Day Year
AUGUST 18 1997

3. Time of Death

9:20 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

8 OCTANT WAY

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

5. Social Security Number

220-70-0950

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

34 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 21, 1963

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md

10b. County

Baltimore

10c. City, Town or Location

Middle River

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8 Octant Way

10f. Zip Code

21220

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: White15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

10th

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Sr. Operator

16b. Kind of Business/Industry

Worthington Steel

17. Father's Name (First, Middle, Last)

Donald Howard Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Pauline Crim

19a. Informant's Name/Relationship (Type, Print)

Pauline Sobul /mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Rt.1 Box Neelyville Missouri 63954

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Kinsey Cemetery

Date

8/24/97

20c. Location - City or Town, State

Harvielle Missouri

21. Signature of Funeral Service Licensee

R. Terry Connelly

22. Name and Address of Facility

Connelly Funeral Home of Essex

300 Mace Ave. Baltimore Maryland 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending
Investigation
6 ☐ Could not be
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. L. A. R. W. Locke, MD

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

AUGUST 18, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

J. L. A. R. W. Locke, MD 111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

AUG 20 1997

32. Registrar's Signature

John Davidson-Randall

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please do not detach for use as the burial-transit card.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please do not detach for use as the burial-transit card.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25134

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|--|--|---|--|--|--|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) CORA B HAGECK | | | | | | 2. Date of Death Month Aug Day 19 Year 97 | | 3. Time of Death 12:29 A | |
| | 4a. Facility Name (If not institution, give street and number) Howard County General Hospital | | | | | | 4b. City, Town, or Location of Death Columbia | | 4c. County of Death Howard | |
| Funeral Director | 5. Social Security Number 519-48-5246 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 54 Yrs. | | 8. Date of Birth (Month, Day, Year) JUNE 30, 1943 | | 9. Birthplace (State or Foreign Country) Pennsylvania | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Md. | | 10b. County Howard | | 10c. City, Town or Location Ellicott City | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number 7647 Stoney Creek Lane | | | | 10f. Zip Code 21043 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: white | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Assistant Manager | | | 16b. Kind of Business/Industry Restaurant | | |
| | 17. Father's Name (First, Middle, Last) James Henderson Bryant, St. | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Geraldine Whoolery | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Geraldine Miceni - sister | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7647 Stoney Creek Lane, Ellicott City, Md. 21043-7906 | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial Park | | Date 8/22/97 | | 20c. Location - City or Town, State Elkridge, Md. | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Gary L. Kaufman Funeral Home at Meadowridge MP 7250 Washington Blvd., Elkridge, Md. 21075 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e. Acute Myocardial Infarction Due to (or as a consequence of): b. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | | |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier ME | | 29c. License number D31473 | | 29d. Date signed (Month, Day, Year) August 19/97 | | | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) PAULICE A. TOTE, MD 4565 Hemlock Lane Way Ellicott City MD 21042 | | | | | | | | | |
| | 31. Date filed (Month, Day, Year) AUG 20 1997 32. Registrar's Signature | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

30

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Howard Gordon Hall

2. Date of Death

Month August 17, 1997

3. Time of Death

01:10 am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Greater Baltimore Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

218-14-6914

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Jan. 4, 1925

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State
Maryland

10b. County

Baltimore

10c. City, Town or Location

Edgemere

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6702 River Drive Road

10f. Zip Code

21219

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1943-4613. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12 Years

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Field Engineer

16b. Kind of Business/Industry

Steel Industry

17. Father's Name (First, Middle, Last)

John E. Hall

18. Mother's Name (First, Middle, Maiden Surname)

Lula Geoghan

19a. Informant's Name/Relationship (Type, Print)

Mrs. Margaret B. Hall/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6702 River Drive Road Edgemere, Maryland 21219

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Oak Lawn Cemetery 8/20/1997

Data

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 2122223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

SEVERE TRIPLE VESSEL CORONARY DISEASE

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

ISCHEMIC CONGESTIVE CARDIOMYOPATHY

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

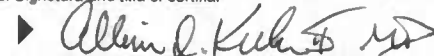
M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of injury - At home, term, street, factory, office
building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D 21336

29d. Date signed (Month, Day, Year)

8/17/97

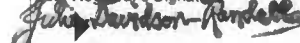
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALVIN D. KUHNY, M.D. 8020 RITCHIE HWY, PASADENA, MD. 21122

31. Date filed (Month, Day, Year)

AUG 20 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After the certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25136

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARY CATHERINE JONES

2. Date of Death

August 18, 1997

3. Time of Death

7:56 PM

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

316-07-1902

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

01/13/1920

9. Birthplace (State or Foreign Country)

Indiana

Usual Residence of Decedent

10a. State

Arizona

10b. County

Maricopa

10c. City, Town or Location

Sun City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

15630 North Lake Forest Drive

10f. Zip Code

85351

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Frank Cosgrove

18. Mother's Name (First, Middle, Maiden Surname)

Rose Hartford

19a. Informant's Name/Relationship (Type, Print)

Dilworth R. Jones

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15630 North Lake Forest Dr. Sun City, Az. 85351

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Hilltop Service Corp.

Date

8/21/97

20c. Location - City or Town, State

Towson, MD

21. Signature of Funeral Service Licensee

Dennis C. Carroll

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.
1050 York Rd. Towson, MD. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

BIVENTRICULAR HEART FAILURE

a.

Due to (or as a consequence of):

REDO CORONARY ARTERY BYPASS SURGERY

b.

Due to (or as a consequence of):

RECENT ACUTE MYOCARDIAL INFARCTION

c.

Due to (or as a consequence of):

TWO DAYS

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and Title of Certifier

Stephen Lincoln

29c. License number

D23045

29d. Date signed (Month, Day, Year)

08/18/97

30. Name and address of person who completed cause of death (from 23a) (Type, Print)

STEPHEN LINCOLN M.D., 7505 OSLER DR. SUITE 306, TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

AUG 20 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: This requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

87 25137

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ERMA VIRGINIA JARRELL

2. Date of Death
Month Day Year

AUG 10, 1997

3. Time of Death

4:30 AM

4a. Facility Name (If not institution, give street and number)

Hospice of the Chesapeake

4b. City, Town, or Location of Death

Linthicum

4c. County of Death

Anne Arundel

5. Social Security Number

226-28-3229

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

MAY 29, 1919

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Md.

10b. County

Anne Arundel

10c. City, Town or Location

Severn

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7764 Telegraph Road

10f. Zip Code

21144

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cafeteria Worker

16b. Kind of Business/Industry

Public School System

17. Father's Name (First, Middle, Last)

Sterling William King

18. Mother's Name (First, Middle, Maiden Surname)

(Unobtainable)

19a. Informant's Name/Relationship (Type, Print)

Thomas W. Campbell, Jr. -son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7764 Telegraph Rd., Severn, Md. 21144

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Mem. Park

Date

8/13/97

20c. Location - City or Town, State

Elkridge, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gary L. Kaufman Funeral Home at Meadowridge M.P.
7250 Washington Blvd., Elkridge, Md. 21075

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Non Small Cell Carcinoma of lung 7 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D47137

29d. Date signed (Month, Day, Year)

August 13, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Peter P Ramirez MD 7845 Oakwood Rd Suite 201, Glen Burnie Md

31. Date filed (Month, Day, Year)

AUG 20 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25138

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Pearl Mary Jenkins

2. Date of Death

Month Day Year
August 17, 1997

3. Time of Death

4:40 AM

4a. Facility Name (If not institution, give street and number)

Eastpoint Nursing & Rehabilitation Center

4b. City, Town, or Location of Death

Dundalk

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

236-96-2162

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 10, 1912

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State
W. Virginia

10b. County

Taylor

10c. City, Town or Location

Rosemont

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

Box 34

10f. Zip Code

26424

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
N/A

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Dependent

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Everett Jenkins

18. Mother's Name (First, Middle, Maiden Surname)

Gertrude Whitehair

19a. Informant's Name/Relationship (Type, Print)

Mrs. Catherine Spinks/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Box 34 Rosemont, West Virginia 26424

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Nema of cemetery, crematory or other place)

I.O.O.F. Cemetery 8/21/1997

Data

20c. Location - City or Town, State

Flemington, WV

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.

7922 Wise Avenue Baltimore, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Possible Acute MI

Due to (or as a consequence of):

b. 1/2 old CVA + Dementia

Due to (or as a consequence of):

c. 1/2 Deep grade 4 Perisacral Bedsores

Due to (or as a consequence of):

d. 1/2 Hospital Pt

Approximate Interval Between Onset and Death

1-2 hrs.

3-4 hours

2 weeks

2-3 wks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D 14221

29d. Date signed (Month, Day, Year)

8.17.97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

T.A. Brown, 223 B. Blvd BALT MD 21221

31. Date filed (Month, Day, Year)

AUG 20 1997

32. Signature of Registrar

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been completed by the attending physician and completely filled in by the funeral director, page 2 should be attached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SADIE F LITTLEFIELD

2. Date of Death
Month Day Year

AUGUST 15, 1997

3. Time of Death

00:34 AM

4a. Facility Name (If not institution, give street and number)

UNION MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

212-16-0929

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
08/23/1919

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6208 EASTERN PKWY.

10f. Zip Code

21206

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

HOUSE WIFE

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

JOHN NORBROOK

18. Mother's Name (First, Middle, Maiden Surname)

ELIZABETH DAILEY

19a. Informant's Name/Relationship (Type, Print)

IRWIN SEIBERT, JR. / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3215 SHANNON DRIVE BALTIMORE, MD 21213

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHESAPEAKE CREMATORY

Date

8/16/97

20c. Location - City or Town, State

BELTSVILLE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

BRADLEY-ASHTON FUNERAL HOME, INC.

2134 WILLOW SPRING ROAD DUNDALK, MD 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. BOWEL INFARCT

7 hours

Due to (or as a consequence of):

b. ATHEROSCLEROTIC VASCULAR DISEASE

5 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE POST BYPASS

ABDOMINAL AORTIC ANEURYSM

LEFT VENTRICULAR DYSFUNCTION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

28. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MD

29c. License number

D 41637

29d. Date signed (Month, Day, Year)

AUGUST 15, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SALIM T RIZK MD 3333 N. Calvert St. Suite 650 Baltimore, MD 21218

31. Date filed (Month, Day, Year)

AUG 20 1997

32. Registrar's Signature

Gina Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Sadie F. Littlefield

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: Within 24 hours after death, this certificate should be signed by the attending physician and completely filled in by the funeral director, prior to its use as the burial-transit permit.

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25140

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOSEPH LLOYD

2. Date of Death

Aug 10 1997

3. Time of Death

1438

4a. Facility Name (If not institution, give street and number)

UNIVERSITY OF MARYLAND

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

19A-16-5271

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

OCT 18, 1913

9. Birthplace (State or Foreign Country)

SPRINGFIELD, MA

Usual Residence of Decedent

10e. State

MD

10b. County

KENT

10c. City, Town or Location

CHESTERTOWN

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

116 SNYDER LANE

10f. Zip Code

21620

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (14 or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CUSTOM INSPECTOR

16b. Kind of Business/Industry

U.S. CIVIL SERVICE

17. Father's Name (First, Middle, Last)

JOSEPH F. LLOYD

18. Mother's Name (First, Middle, Maiden Surname)

SARA ANN MORAN

19e. Informant's Name/Relationship (Type, Print)

William Lloyd

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

116 SNYDER LANE CHESTERTOWN, MD 21620

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SUNSET MEAN-PARK

Date

AUG 14 1997

20c. Location - City or Town, State

SOMERSET, PA.

21. Signature of Funeral Service Licensee

Thomas J. Stankovic

22. Name and Address of Facility

SKARDA F.H. 2829 HUDSON ST. BALTIMORE, MD 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Ruptured Iliac artery aneurysm

Due to (or as a consequence of):

b. Ischemic colon

Due to (or as a consequence of):

c. Fecal peritonitis

Due to (or as a consequence of):

d.

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

D. Stewart

29c. License number

P10249

29d. Date signed (Month, Day, Year)

August 10, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DYLAN STEWART, M.D. UNIVERSITY OF MARYLAND

31. Date filed (Month, Day, Year)

AUG 20 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed within 72 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25141

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ALBERT J. MICHAELSON

2. Date of Death

Month Day Year
AUGUST 16, 1997

3. Time of Death

5:45AM

4e. Facility Name (If not institution, give street and number)

313 ORLEY ROAD

4b. City, Town, or Location of Death

CATONSVILLE

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

194-22-4397

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
01/26/1931

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

CATONSVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

313 ORLEY ROAD

10f. Zip Code

21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

ENTERTAINMENT

16b. Kind of Business/Industry

MUSICIAN

17. Father's Name (First, Middle, Last)

JOSEPH MICHAELSON

18. Mother's Name (First, Middle, Maiden Surname)

SUSAN HALAVAC

19a. Informant's Name/Relationship (Type, Print)

VERNA POLK/ FIANCEE'

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

313 ORLEY ROAD CATONSVILLE, MD 21228

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MEADOWRIDGE MEMORIAL PARK 8/19/97

Data

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

STERLING ASHTON FUNERAL HOME, INC.

736 EDMONSON AVE. CATONSVILLE, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Cancer of lung with wide metastases
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D01786

29d. Date signed (Month, Day, Year)

8/18/97 August 18, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Laurence R. Gallagher MD 716 Maiden Choice home Balt MD 21228

31. Date filed (Month, Day, Year)

AUG 20 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: A death certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25142

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|--|--|---|---------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last) Mary Louise Moylan | | 2. Date of Death Month August Day 14 Year 1997 | | 3. Time of Death 9:00 AM | |
| 4a. Facility Name (If not institution, give street and number) Frederick Villa Nursing Center | | 4b. City, Town, or Location of Death Catonsville | | 4c. County of Death Baltimore | |
| 5. Social Security Number 213-01-7341 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 90 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 02/28/1907 |
| 9. Birthplace (State or Foreign Country) MD | | | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State MD | 10b. County BALTIMORE | 10c. City, Town or Location CATONSVILLE | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 106 WOODWIND ROAD | | 10f. Zip Code 21228 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CLERK | | 16b. Kind of Business/Industry CLOTHING STORE | | | |
| 17. Father's Name (First, Middle, Last) WALLACE BROWN | | 18. Mother's Name (First, Middle, Maiden Surname) MARGARET FRYE | | | |
| 19a. Informant's Name/Relationship (Type, Print) JAMES MOYLAN/ SON | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 106 WOODWIND ROAD CATONSVILLE, MD 21228 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) NEW CATHEDRAL CEMETERY | | 20c. Location - City or Town, State 8/18/97 BALTIMORE, MD | |
| 21. Signature of Funeral Service Licensee Robert S. Quinn | | 22. Name and Address of Facility STERLING ASHTON FUNERAL HOME, INC. 736 EDMONDSON AVE. CATONSVILLE, MD 21228 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Lung Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury M | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier Raymond Miller MD | | 29c. License number 1547683 | | 29d. Date signed (Month, Day, Year) 8/15/97 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raymond Miller 25 Main Street, Suite 200 Reisterstown, MD 21136 | | | | | |
| 31. Date filed (Month, Day, Year) AUG 20 1997 | | 32. Registrar's Signature J. Davidson | | | |

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 25143**
Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|--|---|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Eugene Michael Noppenberger | | | | 2. Date of Death Month Aug. Day 1, Year 1997 | | 3. Time of Death 7:00 PM | |
| | 4a. Facility Name (If not institution, give street and number) 695 Windsor Drive | | | | 4b. City, Town, or Location of Death Westminister | | 4c. County of Death Carroll | |
| Funeral Director | 5. Social Security Number 21932-2474 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 62 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) July 3, 1935 | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | 10a. State Maryland | | 10b. County Carroll | |
| 10c. City, Town or Location Westminister | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 695 Windsor Drive | | 10f. Zip Code 21158 |
| 10g. Citizen of What Country? U.S.A. | | | | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| 14. Race - American Indian, Black, White, etc. Specify: White | | | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Technician | | 16b. Kind of Business/Industry Electronic |
| 17. Father's Name (First, Middle, Last) George Joseph Noppenberger | | | | 18. Mother's Name (First, Middle, Maiden Surname) Ellen Mary Parker | | 19a. Informant's Name/Relationship (Type, Print) Barbara A. Noppenberger/wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 695 Windsor Drive, Westminister, MD 21158 |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) | | 20c. Location - City or Town, State | | 20d. Date |
| 21. Signature of Funeral Service Licensee <i>Ronald S. Wade</i> Director | | | | 22. Name and Address of Facility State Anatomy Board-655 W. Baltimore Street Baltimore, Maryland 21201 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MULTIPLE MYELOMA | | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death) | | | | Due to (or as a consequence of): | | Due to (or as a consequence of): | | Due to (or as a consequence of): |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Due to (or as a consequence of): | | Due to (or as a consequence of): | | Due to (or as a consequence of): |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) |
| 28b. Time of Injury M | | | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier <i>[Signature]</i> | | 29c. License number 018099 |
| 29d. Date signed (Month, Day, Year) 8-6-97 | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P.O. Box 591 Westminister | | 31. Date filed (Month, Day, Year) AUG 20 1997 | | 32. Registrar's Signature <i>[Signature]</i> |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

97-4609-510

wlc

MARTIN M.

Items: 23a part I, 27, 28a-f per MEO G-751 9/19/97, dh
NEIGHOFF

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25144

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARTIN M. NEIGHOFF

2. Date of Death

Month Day Year
August 15, 1997

3. Time of Death

355p

4a. Facility Name (If not institution, give street and number)

JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

218-56-0698

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

44

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 10, 1953

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

1635 Essex Towne Circle

10f. Zip Code

21221

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Road Construction

17. Father's Name (First, Middle, Last)

Martin E. Neighoff

18. Mother's Name (First, Middle, Maiden Surname)

Ruth A. Hutchins

19a. Informant's Name/Relationship (Type, Print)

Susan Neighoff/sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1635 Essex Towne Circle Baltimore Md. 21221

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metro Crematory Inc. 8/19/97

Date

20c. Location - City or Town, State

Baltimore Md.

21. Signature of Funeral Service Licensee

R. Terry Connelly

22. Name and Address of Facility

Connelly Funeral Home of Essex

300 Mace Ave. Baltimore Md. 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. ALCOHOL AND NARCOTIC INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown24a. Was an autopsy
performed?☒ Yes ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?☒ Yes ☐ No25. Was case referred to medical
examiner?
☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☒ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☐ Natural ☐ Pending
investigation
☐ Accident ☒ Suicide
☐ Homicide ☒ Could not be
determined

28a. Date of Injury

(Month, Day, Year)

found: 8/15/97

28b. Time of

Injury

found: 3:20

28c. Injury at

Work?

☐ Yes ☒ No

28d. Describe how Injury occurred

unknown

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

found at a friend's home

28f. Location (Street and Number or Rural Route Number,
City or Town, State) found at 927 N.
Collington St., Baltimore, Maryland29a. Certifier
(Check only
one)☐ Certifying Physician☒ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and Title of Certifier

David R Fowler

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

August 16, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David R Fowler

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

AUG 20 1997

32. Registrar's Signature

Fiona Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital of Maryland: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: This certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25145

Item5 9-9-97 FilmG751 W.H.Per A. Board

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | |
|---|---|---|---|--|--|--|--|---|------------------------------------|---|--|--|-------------------------------------|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) HELEN HUGHES PHYSIOC | | | 2. Date of Death Month Day Year Aug 15 1997 | | 3. Time of Death 3:15a.m. | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) 20657 BEAVER CREEK ROAD | | | 4b. City, Town, or Location of Death HAGERSTOWN | | 4c. County of Death WASHINGTON | | | | | | | |
| Funeral Director | 5. Social Security Number 214-46-5776 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 88 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 7-4-09 | | | | | | |
| | 9. Birthplace (State or Foreign Country) MARYLAND | | Usual Residence of Decedent | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MARYLAND | 10b. County WASHINGTON | 10c. City, Town or Location HAGERSTOWN | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| | 10e. Street and Number 20657 BEAVER CREEK ROAD | | | 10f. Zip Code 21740 | | 10g. Citizen of What Country? USA | | | | | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MOTHER / HOUSEWIFE | | 16b. Kind of Business/Industry HOME | | | | | | | | |
| | 17. Father's Name (First, Middle, Last) JOSEPH KNODE HOFFMAN | | | 18. Mother's Name (First, Middle, Maiden Surname) IOLA ELIZABETH HUGHES | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) PAULA WORTHINGTON - DAUGHTER | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9775 BEAVER CREEK CHURCH ROAD, HAGERSTOWN MD 21740 | | | | | | | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) STATE ANATOMY BOARD | | 20c. Location - City or Town, State BALTIMORE, MARYLAND | | | | | | | | |
| | 21. Signature of Funeral Service Licensee | | | 22. Name and Address of Facility State Anatomy Bd - 655 W. Baltimore St, BALTIMORE MD 21201 | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | |
| | <table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Cerebrovascular Accident</td> <td rowspan="4">Approximate Interval Between Onset and Death 34 hours 2 years</td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. Due to (or as a consequence of): Arteriosclerotic Cerebral Vessel Disease</td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> </tr> </table> | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. Cerebrovascular Accident | Approximate Interval Between Onset and Death 34 hours 2 years | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): Arteriosclerotic Cerebral Vessel Disease | c. Due to (or as a consequence of): |
| Immediate Cause (Final disease or condition resulting in death) | a. Cerebrovascular Accident | Approximate Interval Between Onset and Death 34 hours 2 years | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): Arteriosclerotic Cerebral Vessel Disease | | | | | | | | | | | | |
| | c. Due to (or as a consequence of): | | | | | | | | | | | | |
| | d. Due to (or as a consequence of): | | | | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. None | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | |
| 29b. Signature and title of certifier Robert Bull MD Personal Physician | | 29c. License number 004359 | | 29d. Date signed (Month, Day, Year) Aug 15 1997 | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Bull MD 1459 Potomac Ave. Hagerstown | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 20 1997 | | 32. Registrar's Signature | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

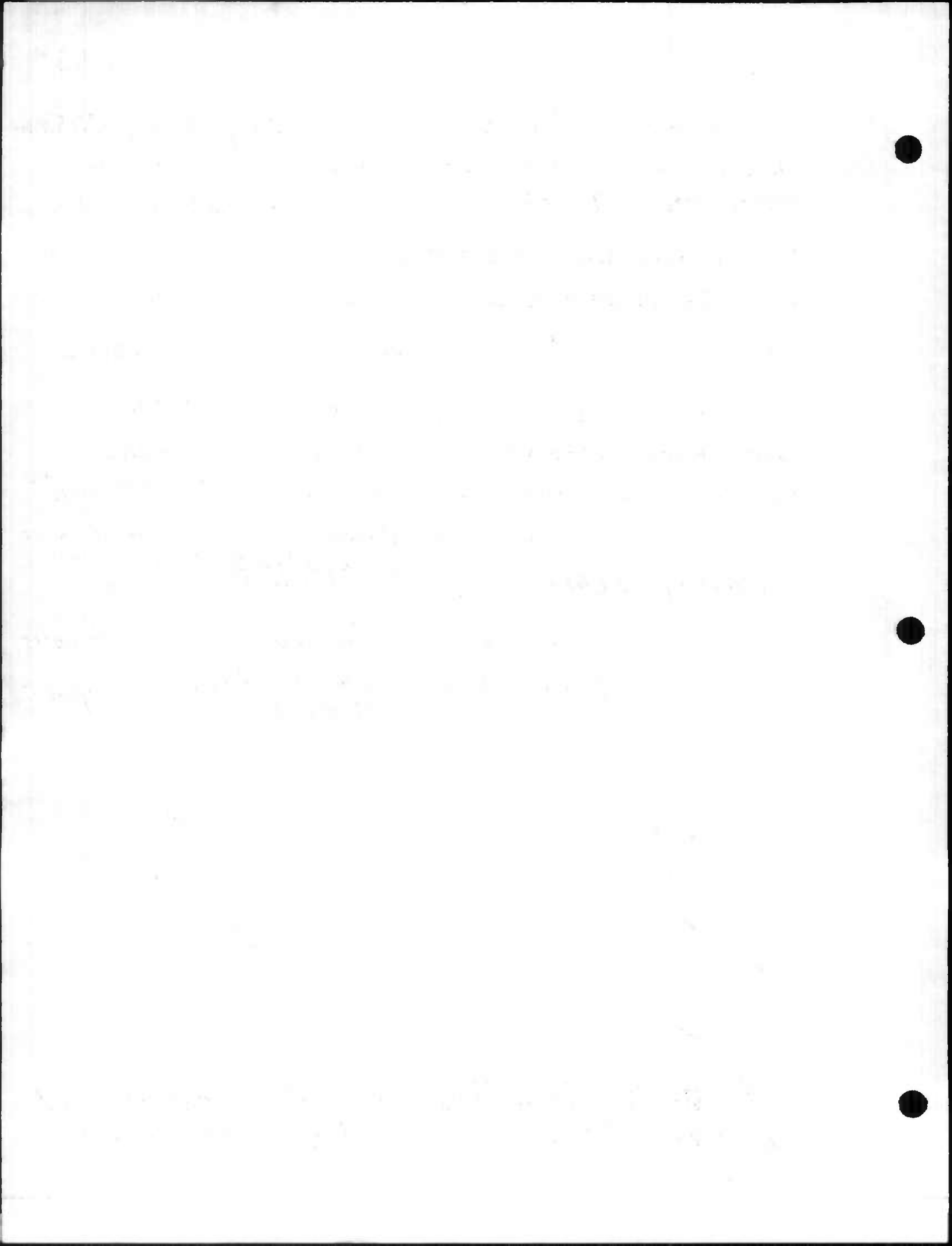
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25146

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERTA PETERKIN

2. Date of Death

Month Day Year
AUGUST 17, 1997

3. Time of Death

16:44

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

213-34-4394

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

68

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JUL 27, 1929

9. Birthplace (State or Foreign Country)

NC

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTO

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1508 N. BIDDLE ST

10f. Zip Code

21213

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
9thCollege (1-4 or 5+)
N/A16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

ASSEMBLY WORKER

16b. Kind of Business/Industry

CUP CO

17. Father's Name (First, Middle, Last)

UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname)

MAGGIE FLOYD

19a. Informant's Name/Relationship (Type, Print)

JAMES PETERKIN/HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1508 N. BIDDLE ST BALTO, MD 21213

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

MT. ZION CEM

Date

AUG 22
1997

20c. Location - City or Town, State

BALTO, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

BETTS FUNERAL HOME
1129 N. CAROLINE ST BALTO, MD 2121323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Ventricular Fibrillation

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

24 Hours

b. Congestive Heart Failure

Due to (or as a consequence of):

5 years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

anoxic encephalopathy

acute renal failure

acute hepatic failure

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
injury

M

28c. Injury at
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

AUGUST 17, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SONJA FREDRICKSON 600 N. WOLFE STREET BALTIMORE, MD 21287

31. Date filed (Month, Day, Year)

AUG 20 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The doctor requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, papers should be detached for use as the burial-transit
document.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25147

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|---|---------------------------------------|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>Regina T Phelps</u> | | | | 2. Date of Death Month Day Year <u>AUGUST 15, 1997</u> | | 3. Time of Death <u>8:17 a</u> | |
| | 4e. Facility Name (If not institution, give street and number) <u>THE JOHNS HOPKINS HOSPITAL</u> | | | | 4b. City, Town, or Location of Death <u>BALTIMORE CITY</u> | | 4c. County of Death <u>n/a</u> | |
| Funeral Director | 5. Social Security Number <u>220-70-1885</u> | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) <u>77</u> Yrs. | | 8. Date of Birth (Month, Day, Year) <u>Aug. 8 1920</u> | |
| | 9. Birthplace (State or Foreign Country) <u>Maryland</u> | | 10a. State <u>Md.</u> | | 10b. County <u>Anne Arundel Co.</u> | | 10c. City, Town or Location <u>Pasadena</u> | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number <u>8030 L. Abbey Court</u> | | 10f. Zip Code <u>21122</u> | | 10g. Citizen of What Country? <u>USA</u> | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <u>white</u> | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>0</u> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Secretary</u> | | 16b. Kind of Business/Industry <u>Westinghouse</u> | | | |
| | 17. Father's Name (First, Middle, Last) <u>William T. Lorenz</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <u>Margaret O'Donnell</u> | | | |
| | 19a. Informant's Name/Relationship (Type, Print) <u>Burton W. Phelps (Son)</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1213 Lorene Drive, Pasadena, Md. 21122</u> | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Glen Haven Memorial Pk.</u> | | Date <u>Aug. 18 1997</u> | | 20c. Location - City or Town, State <u>Glen Burnie, Md.</u> | |
| | 21. Signature of Funeral Service Licensee <u>[Signature]</u> | | | | 22. Name and Address of Facility <u>McCully-Polyniak Funeral Home of Pasadena 3204 Mountain Road, Pasadena, Md. 21122</u> | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Stroke</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death <u>8 days</u> |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury <u>M</u> | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <u>[Signature] Resident Physician</u> | | 29c. License number <u>RES-000</u> | | 29d. Date signed (Month, Day, Year) <u>August 15, 1997</u> | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <u>Eric Peck The Johns Hopkins Hospital Baltimore, MD</u> | | | | | | | | |
| 31. Date filed (Month, Day, Year) <u>AUG 20 1997</u> | | 32. Registrar's Signature <u>[Signature]</u> | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar

DHMM 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25148

| | | | | | | | | | | | | | | |
|---|--|--------------------------|--|---|---|--------------------------|--------------------------------|---|--------------------------------|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Linda N. Rosemere | | | | 2. Date of Death Month Day Year AUGUST 15, 1997 | | | | 3. Time of Death 1553 | | | | | |
| | 4a. Facility Name (If not institution, give street and number) St. Agnes Hospital | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death N/A | | | | | |
| Funeral Director | 5. Social Security Number 215-36-0250 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 57 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | | 8. Date of Birth (Month, Day, Year) Nov. 28, 1939 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | | | | | | | | | | |
| 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Arbutus | | | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | |
| 10e. Street and Number 1221 Birch Avenue | | | | 10f. Zip Code 21227 | | | | 10g. Citizen of What Country? United States | | | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: white | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker | | | | 16b. Kind of Business/Industry own home | | | | | | |
| 17. Father's Name (First, Middle, Last) Charles S. Newton | | | | 18. Mother's Name (First, Middle, Maiden Surname) Helen McCall | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Conrad J. Rosemere Jr. Hus | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1221 Birch Avenue Arbutus, Maryland 21227 | | | | | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Dorchester Memorial | | | | Date 8/18 | | 20c. Location - City or Town, State Cambridge, Maryland | | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Ambrose Funeral Home, Inc. Arbutus 1328 Sulphur Spring Road 21227 | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute MI Due to (or as a consequence of): b. ASCVD Due to (or as a consequence of): c. Obesity Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Approximate Interval Between Onset and Death unknown unknown | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier (Attending Physician) | | | | 29c. License number 051853 | | | | 29d. Date signed (Month, Day, Year) 8/15/97 | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Silverman, MD Every Dept St Agnes Healthcare Balt, MD 21229 | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 20 1997 | | | | 32. Registrar's Signature | | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25149

| | | | | | | | | | | | |
|--|--|--|---|--|--|---------------------------------|--|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Beatrice Parker Shull | | | | 2. Date of Death Month August Day 19 Year 1997 | | | | 3. Time of Death 12:45 AM | | |
| | 4a. Facility Name (If not Institution, give street and number) Multi Medical Center | | | | 4b. City, Town, or Location of Death Towson | | | | 4c. County of Death Baltimore | | |
| Funeral Director | 5. Social Security Number 216-44-0718 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 84 Yrs. | | 8. Date of Birth (Month, Day, Year) August 12, 1913 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| | Usual Residence of Decedent | | | | 10a. State MD | | | | 10b. County Baltimore | | |
| To Be Completed by Funeral Director | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| | 10e. Street and Number 1118 Ramblewood Road | | | | 10f. Zip Code 21239 | | | | 10g. Citizen of What Country? USA | | |
| | 11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: white | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+) 5+ | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher | | | | 16b. Kind of Business/Industry Public School | | |
| | 17. Father's Name (First, Middle, Last) Granville Parker | | | | 18. Mother's Name (First, Middle, Maiden Surname) Sarah NMN Wilkens | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Michael Shull/son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9802 Georgia Ave. Silver Spring, MD 20902 | | | | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp. | | 20c. Date 08/20/97 | | 20d. Location - City or Town, State Towson, Maryland | | | | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Dementia (End Stage) Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier  | | | | 29c. License number D39-757 | | 29d. Date signed (Month, Day, Year) August 19, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lutfi A. Sayyur, M.D. 5601 Loch Raven Blvd. Baltimore, MD 21239 | | | | 31. Date filed (Month, Day, Year) AUG 20 1997 | | | | 32. Registrar's Signature  | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

3

State
Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25150

| | | | | | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ERNEST THOMAS SCHAFER | | | | 2. Date of Death Month 8 Day 15 Year 97 | | 3. Time of Death 2:00AM | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) 1433 Roland Heights Avenue | | | | 4b. City, Town, or Location of Death Baltimore City | | 4c. County of Death N/A | | | | | | | | |
| Funeral Director | 5. Social Security Number 219-12-7652 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) Yrs. 73 | | 8. Date of Birth (Month, Day, Year) June 16, 1924 | | 9. Birthplace (State or Foreign Country) MD | | | | | | |
| | Usual Residence of Decedent | | | | 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | |
| 10e. Street and Number 1433 Roland Heights Avenue | | | | 10f. Zip Code 21211 | | | | 10g. Citizen of What Country? U.S.A. | | | | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Shopstewart | | | | 16b. Kind of Business/Industry M.T.A. | | | | | | | |
| 17. Father's Name (First, Middle, Last) Ernest J. Schafer | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary J. Thomas | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Ryland Schafer /Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2813 Southview Road Ellicott City, MD 21042 | | | | | | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) crestlawn | | Date Aug 20 '97 | | 20c. Location - City or Town, State Marriottsville, MD | | | | | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility STERLING ASHTON FUNERAL HOME, INC. 736 EDMONDSON AVE. CATONSVILLE, MD 21228 | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Squamous cell Esophageal CA - metastatic Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death 1 mo - btw Dx & Death | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary artery disease Hypertension COPD | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier | | | | 29c. License number P35069 | | 29d. Date signed (Month, Day, Year) 8/15/97 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Sandra Hairston, MD 3100 Wyman Park Dr. Baltimore, MD | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 20 1997 | | | | 32. Registrar's Signature | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be attached and used as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

State of Maryland / Department of Health and Mental Hygiene 97 25151
Certificate of Death

2515

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene

97 25152

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EMMA ANNIE SHEPPARD

2. Date of Death

Month Day Year
AUGUST 12 1997

3. Time of Death

10:00 AM

4a. Facility Name (If not institution, give street and number)

Saint Elizabeth's Rehabilitation and Nursing Center

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

215-16-6898

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept 23 1913

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Baltimore (Brooklyn Park)

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4 West Fourteenth Avenue

10f. Zip Code

21225

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
6

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Button Hole Maker

16b. Kind of Business/Industry

Coat Factory

17. Father's Name (First, Middle, Last)

Richard Sallin

18. Mother's Name (First, Middle, Maiden Surname)

Mary Houdek

19a. Informant's Name/Relationship (Type, Print)

Ms. Shirley R. England (Niece)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

315 Church St., Baltimore, Maryland 21225

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Cedar Hill Cemetery Aug 14, 1997

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Kevin E. Ecker

22. Name and Address of Facility

McCully-Polyniak Funeral Home of Brooklyn
237 E. Patapsco Ave., Balto., Md. 21225-185623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. OVARIAN CANCER

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

4 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

William M. Russell MD

29c. License number

D30182

29d. Date signed (Month, Day, Year)

AUGUST 12, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

WILLIAM M. RUSSELL MD 3421 AENSON AVE BALTIMORE MD 21227

31. Date filed (Month, Day, Year)

AUG 20 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25153

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

RUTHANN STALLS

2. Date of Death

AUGUST

Day

12

Year

1997

3. Time of Death

3:35 PM

4a. Facility Name (If not institution, give street and number)

HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

216-32-2956

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

60

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Feb 16, 1937

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore (Curtis Bay)

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3930 Pennington Avenue

10f. Zip Code

21226

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12College (1-4 or 5+)
+216a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Associate

16b. Kind of Business/Industry

Walmart

17. Father's Name (First, Middle, Last)

Eugene

Marsh

18. Mother's Name (First, Middle, Maiden Surname)

Mabel

Sparks

19a. Informant's Name/Relationship (Type, Print)

Mr. Dewey Allen Stalls (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3930 Pennington Ave., Baltimore, Maryland 21226

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metro Crematory, Inc.

Date

20c. Location - City or Town, State

Catonsville, Maryland

21. Signature of Funeral Service Licensee

Kevin E. Ecker

22. Name and Address of Facility

McCully-Polyniak Funeral Home of Brooklyn
237 E. Patapsco Ave., Baltimore, Md. 21225-185623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. UNRESECTABLE SQUAMOUS CELL CARCINOMA OF

Approximate
Interval Between
Onset and Death

3 months

Due to (or as a consequence of):

LEFT LUNG

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SEPTICEMIA

CONGESTIVE HEART FAILURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

V. Chandrasekhar Reddy

PGY II IN
INTERNAL MEDICINE

29c. License number

P10828

29d. Date signed (Month, Day, Year)

AUGUST, 12, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHANDRASEKHAR REDDY VASAM REDDY, 3001 S. HANOVER STREET, BALTIMORE, MD 21225

31. Date filed (Month, Day, Year)

AUG 20 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25154

Item 23 Part I 8-20-97 Film G750 W.H. Per Doctor

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Ronald J. Schwabe | | | | 2. Date of Death Month August Day 3 Year 1997 | | 3. Time of Death 10:48 a.m. | |
| | 4e. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE CITY | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 072-34-6892 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 53 Yrs. | If Under 1 Year Months 0 Days 0 | If Under 24 Hrs. Hours 0 Min. 0 | 8. Date of Birth (Month, Day, Year) 8/18/43 | 9. Birthplace (State or Foreign Country) N.Y. |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Pa. | | 10b. County Luzerne | | 10c. City, Town or Location Hazleton | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 100 Wilson Dr. | | | | 10f. Zip Code 18201 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Chairman of Board | | 16b. Kind of Business/Industry Manufacturing Co. | | |
| 17. Father's Name (First, Middle, Last) Herman Schwabe | | | | 18. Mother's Name (First, Middle, Maiden Surname) Greth Spanier | | | | |
| 19e. Informant's Name/Relationship (Type, Print) Mrs. Shirli Schwabe/wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 Wilson Dr. Hazleton, Pa. 18201 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Riverside Cemetery | | Date 8/5/97 | | 20c. Location - City or Town, State Saddle Brook, N.J. | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e. Respiratory failure DUE TO LUNG TRANSPLANT Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | Approximate Interval Between Onset and Death 3 weeks |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier Eric Peck Resident Physician | | 29c. License number RES-00 | | 29d. Date signed (Month, Day, Year) August 3, 1997 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eric Peck Johns Hopkins Hospital, Baltimore, MD | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 20 1997 | | 32. Registrar's Signature | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25155

Item 1 8-20-97 Film G750 W.H.Per Doctor

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ERCEL SYDNOR Sydnor | | | | 2. Date of Death Month Day Year AUGUST 9 1997 | | 3. Time of Death 03:10 | |
| | 4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE CITY | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 213-32-1629 | | 6. Sex 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) Yrs. 63 | | 8. Date of Birth (Month, Day, Year) Aug 12, 1933 | |
| | 9. Birthplace (State or Foreign Country) Va. | | 10a. State Md. | | 10b. County N/A | | 10c. City, Town or Location Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 1302 Longwood Street | | 10f. Zip Code 21216 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Operator | | 16b. Kind of Business/Industry Western Electric | | 17. Father's Name (First, Middle, Last) William Sydnor | |
| | 18. Mother's Name (First, Middle, Maiden Surname) Iver Ellis | | 19. Informant's Name/Relationship (Type, Print) sister Sophonra Peters | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | 20. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | |
| Physician /Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Memorial Park | | 20c. Location - City or Town, State Baltimore, Md. | | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | 22. Name and Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216 | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. PNEUMONIA Due to (or as a consequence of): MULTIPLE MYELOMA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last HYPOTHYROIDISM, ANEMIA Due to (or as a consequence of): | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | |
| | 29b. Signature and title of certifier <i>[Signature]</i> | | 29c. License number RES-000 | | 29d. Date signed (Month, Day, Year) AUGUST 9, 1997 | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) KATHERINE DUNLEAVY, MD, 606 N WOLFE ST; TOWER 110; BALTIMORE, MD 21287 | |
| State Registrar | 31. Date filed (Month, Day, Year) AUG 20 1997 | | 32. Registrar's Signature <i>[Signature]</i> | | 33. Date of Death (Month, Day, Year) AUGUST 9, 1997 | | 34. Time of Death 03:10 | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25156

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>Clyde Preston Stallard</i> | | | | 2. Date of Death Month <i>August</i> Day <i>18</i> , Year <i>1997</i> | | 3. Time of Death <i>12:55 AM</i> | |
| | 4a. Facility Name (If not institution, give street and number) <i>Genesis Heritage Nursing Home</i> | | | | 4b. City, Town, or Location of Death <i>Dundalk</i> | | 4c. County of Death <i>Baltimore</i> | |
| Funeral Director | 5. Social Security Number <i>579-03-8264</i> | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) <i>85</i> Yrs. | | 8. Date of Birth (Month, Day, Year) <i>Aug. 6, 1912</i> | |
| | 9. Birthplace (State or Foreign Country) <i>Virginia</i> | | 10a. State <i>Maryland</i> | | 10b. County <i>Baltimore</i> | | 10c. City, Town or Location <i>Dundalk</i> | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number <i>3024 Liberty Parkway</i> | | 10f. Zip Code <i>21222</i> | |
| | 10g. Citizen of What Country? <i>United States</i> | | | | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <i>1941-45</i> | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: <i>White</i> | | 15. Decedent's Education (Specify only highest grade completed) <i>8 Years</i> | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Steel Worker Ship Yard</i> | | | | 16b. Kind of Business/Industry <i>Steel Industry</i> | | 17. Father's Name (First, Middle, Last) <i>Ballard Stallard</i> | |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Surname) <i>Margaret Adams</i> | | | | 19a. Informant's Name/Relationship (Type, Print) <i>Gladys Stallard/Wife</i> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3024 Liberty Parkway Dundalk, Maryland 21222</i> | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Oak Lawn Cemetery</i> | | 20c. Location - City or Town, State <i>Baltimore, Maryland</i> | | 20d. Date <i>8/20/1997</i> | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility <i>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222</i> | | | |
| | 23a. Part I. Enter the disease or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <i>Pneumonia</i> Due to (or as a consequence of): <i>Clinic deterioration lung disease years</i> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>Cerebrovascular disease</i> <i>Coronary artery disease</i> | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) <i>8/19/97</i> | | | |
| | 28b. Time of Injury <i>M</i> | | | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier <i>[Signature]</i> | | | | 29c. License number <i>D08358</i> | | | |
| | 29d. Date signed (Month, Day, Year) <i>8/19/97</i> | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>GRACIO PATRICIO</i> <i>8903 HARTFORD ROAD BALT. MD. 21234</i> | | | |
| State Registrar | 31. Date filed (Month, Day, Year) <i>AUG 20 1997</i> | | | | 32. Registrar's Signature <i>[Signature]</i> | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 25157**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

| | | | | | | | | | |
|---|--|---|--|--|--|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last) Virginia Stofko | | | | 2. Date of Death Month August Day 19 Year 1997 | | | | 3. Time of Death 08:00 | |
| 4a. Facility Name (If not institution, give street and number) Johns Hopkins Bayview Medical Ctr. | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death N/A | |
| 5. Social Security Number 218-26-1970 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 69 Yrs. | | 8. Date of Birth (Month, Day, Year) Feb. 1, 1928 | | 9. Birthplace (State or Foreign Country) USA | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State MD | | 10b. County Baltimore | | 10c. City, Town or Location Dundalk | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 7137 Holabird Avenue | | | | 10f. Zip Code 21222 | | 10g. Citizen of What Country? US | | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years College (1-4 or 5+) | | | | 15a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary | | | 15b. Kind of Business/Industry Automobile Industry | | |
| 17. Father's Name (First, Middle, Last) Gabriel Stephen Stofko | | | | 18. Mother's Name (First, Middle, Maiden Surname) Anna Mary Yuhas | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Frances H. Stofko/Sister | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7137 Holabird Avenue Dundalk, Maryland 21222 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Heart of Mary Cem. | | Date 8/22/97 | | 20c. Location - City or Town, State Dundalk, Maryland | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 | | | | | |

To Be Completed by Funeral Director

Physician
/Medical
Examiner

| | | | |
|---|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | Approximate Interval Between Onset and Death | |
| Immediate Cause (Final disease or condition resulting in death) | | 8 months | |
| e. Advanced stage lung cancer Due to (or as a consequence of): | | | |
| b. Lung cancer with metastasis to brain Due to (or as a consequence of): | | 3 months | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | |
| c. Due to (or as a consequence of): | | | |
| d. Due to (or as a consequence of): | | | |

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier | | 29c. License number 97012 | | 29d. Date signed (Month, Day, Year) 8/19/97 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Irene Dankwa Johns Hopkins Bayview Medical Center | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 20 1997 | | 32. Registrar's Signature | | | | | |

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25158

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

John Talford

2. Date of Death

Month

Day

Year

Aug 14 1997

3. Time of Death

7:00 AM

4a. Facility Name (If not institution, give street and number)

Joseph Ritchey Hospice

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

5. Social Security Number

247-32-5916

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
09-29-15

9. Birthplace (State or Foreign Country)

NC

Usual Residence of Decedent

10a. State

Md

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2618 Llewelyn Avenue

10f. Zip Code

21213

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

3rd. Grade

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

various trades

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Unknown

19a. Informant's Name/Relationship (Type, Print)

Cornelia E. Jones

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2627 Llewelyn Avenue Baltimore, Maryland 21213

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Voshell Mem. Gardens 08-16-97 Dundalk, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Karen M. Roger

22. Name and Address of Facility

Baltimore, Maryland 21202

WM.C. March FH 1101 E. North Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)e. CARCINOMA Abdomen (unknown primary) 1 month
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of Certifier

Robert C. Lawin MD

29c. License number

D08900

29d. Date signed (Month, Day, Year)

8.14.97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Robert C. Lawin MD 828 N. Eutaw St. Balto. MD. 21201

31. Date filed (Month, Day, Year)

AUG 20 1997

32. Registrar's Signature

John G. Anderson

State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed with the Registrar of the Department of Health and Mental Hygiene. If item 27 is marked other than "Natural," or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25159

Item 16b 8-20-97 Film G750 W.H.Per F/H

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|---|---|---|--|--|---|---|--|---|--------------------------------------|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>Maria THOMPSON</i> | | | | | | 2. Date of Death Month <i>July</i> Day <i>31</i> Year <i>1997</i> | | 3. Time of Death <i>11:45 PM</i> | | |
| | 4a. Facility Name (If not institution, give street and number) <i>Howard County General Hospital</i> | | | | | | 4b. City, Town, or Location of Death <i>Columbia</i> | | 4c. County of Death <i>Howard</i> | | |
| Funeral Director | 5. Social Security Number <i>228-56-9453</i> | | 8. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) <i>83</i> Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | | |
| | 6. Date of Birth (Month, Day, Year) <i>Jan 14, 1914</i> | | 9. Birthplace (State or Foreign Country) <i>Virginia</i> | | 10. Usual Residence of Decedent 10a. State <i>VA</i> 10b. County <i>Charlotte</i> 10c. City, Town or Location <i>Drakes Branch</i> 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 11. Street and Number <i>Post Office Box 478</i> | | 12. Zip Code <i>23937</i> | | |
| 13. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 14. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 15. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 16. Race - American Indian, Black, White, etc. Specify: <i>Black</i> | | 17. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>7</i> College (1-4 or 5+) | | 18. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Housewife</i> | |
| 19. Father's Name (First, Middle, Last) <i>Daniel Overbey</i> | | 20. Mother's Name (First, Middle, Maiden Surname) <i>Anna</i> | | 21. Informant's Name/Relationship (Type, Print) <i>daughter</i> <i>Ledla T. Jenkins</i> | | 22. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3048 Memory Lane Silver Spring, Md 20904</i> | | 23. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 24. Place of Disposition (Name of cemetery, crematory or other place) <i>Mossing Ford Baptist Church Cemetery</i> | |
| 25. Signature of Funeral Service Licensee <i>Nelson E. Greene</i> | | 26. Name and Address of Facility <i>Greene Funeral Home</i> <i>814 Franklin St Alexandria, VA 22314</i> | | 27. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <i>Pneumonia</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. <i>Septic</i> | | 28. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Renal Failure</i> | | 29. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 30. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 31. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 32. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 33. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 34. Date of injury (Month, Day, Year) <i>Aug 1, 1997</i> | | 35. Time of injury <i>M</i> | | 36. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 37. Date of injury (Month, Day, Year) <i>Aug 1, 1997</i> | | 38. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 39. Location (Street and Number or Rural Route Number, City or Town, State) | | 40. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 41. Signature and title of Certifier <i>[Signature]</i> | | 42. License number <i>D22856</i> | |
| 43. Date signed (Month, Day, Year) <i>August 1, 1997</i> | | 44. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Deborah L. Levine, MD 11055 Little Patuxent Pkwy, Columbia, Md 21044</i> | | 45. Date filed (Month, Day, Year) <i>AUG 20 1997</i> | | 46. Registrar's Signature <i>John Davidson-Randall</i> | | 47. State Registrar | | 48. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25160

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM TATCHYN

2. Date of Death

AUGUST 9, 1997

3. Time of Death

8:00 am

4a. Facility Name (If not institution, give street and number)

2210 EASTLAKE ROAD

4b. City, Town, or Location of Death

TIMONIUM

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

219-30-2008

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 1, 1916

9. Birthplace (State or Foreign Country)

UKRAINE

Usual Residence of Decedent

10e. State

MD.

10b. County

BALTIMORE

10c. City, Town or Location

TIMONIUM

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

2210 EASTLAKE ROAD

10f. Zip Code

21093

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MEAT PACKER

16b. Kind of Business/Industry

GOETZE'S MEAT CO.

17. Father's Name (First, Middle, Last)

MICHAEL TATCHYN

18. Mother's Name (First, Middle, Maiden Surname)

MARIA ZUBRYCKA

19a. Informant's Name/Relationship (Type, Print)

STEPHANIA TATCHYN/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2210 EASTLAKE ROAD, TIMONIUM, MD. 21093

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ST. MICHAEL'S UKR. CEM 8/12/97 BALTIMORE, MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

LILLY & ZEILER INC. 1901 EASTERN AVE. 21231

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D-12550

29d. Date signed (Month, Day, Year)

8/11/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

2801 YORK RD Towson Md 21204

31. Date filed (Month, Day, Year)

AUG 20 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

ITEM#17 PER F.H. FLM#G750 8/27/97 J.A.

1. Decedent's Name (First, Middle, Last)

Clyde F. Walters

2. Date of Death

August 19, 1997

3. Time of Death

6:50 AM

Physician
/Medical
Examiner

4a. Facility Name (If not institution, give street and number)

3930 Morgan Mill Road

4b. City, Town, or Location of Death

Glen Arm

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

115-01-3349

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 26, 1908

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Glen Arm

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3930 Morgan Mill Road

10f. Zip Code

21057

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No WWII
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Assist. Vice Pres./Superintendent

16b. Kind of Business/Industry

Stevadors

17. Father's Name (First, Middle, Last)

William Franklin Walter WALTERS

18. Mother's Name (First, Middle, Maiden Surname)

Pansy Blossom Smith

19a. Informant's Name/Relationship (Type, Print)

Mrs. Elizabeth Walters

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

same as #10a - #10f

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hilltop Service Corp. 8/20/97

Date

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee

Jeffrey L. Gair

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.
1050 York Rd. - Towson, Md. 21204

23a. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Congestive Heart Failure years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Ischemic Heart Disease years

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

Chronic low back pain

Peripheral Vascular disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Evangelos Lignos MD

29c. License number

D19589

29d. Date signed (Month, Day, Year)

8-19-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Evangelos Lignos, M.D.

7801 York Rd. Towson, Md. 21204

31. Date filed (Month, Day, Year)

AUG 20 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

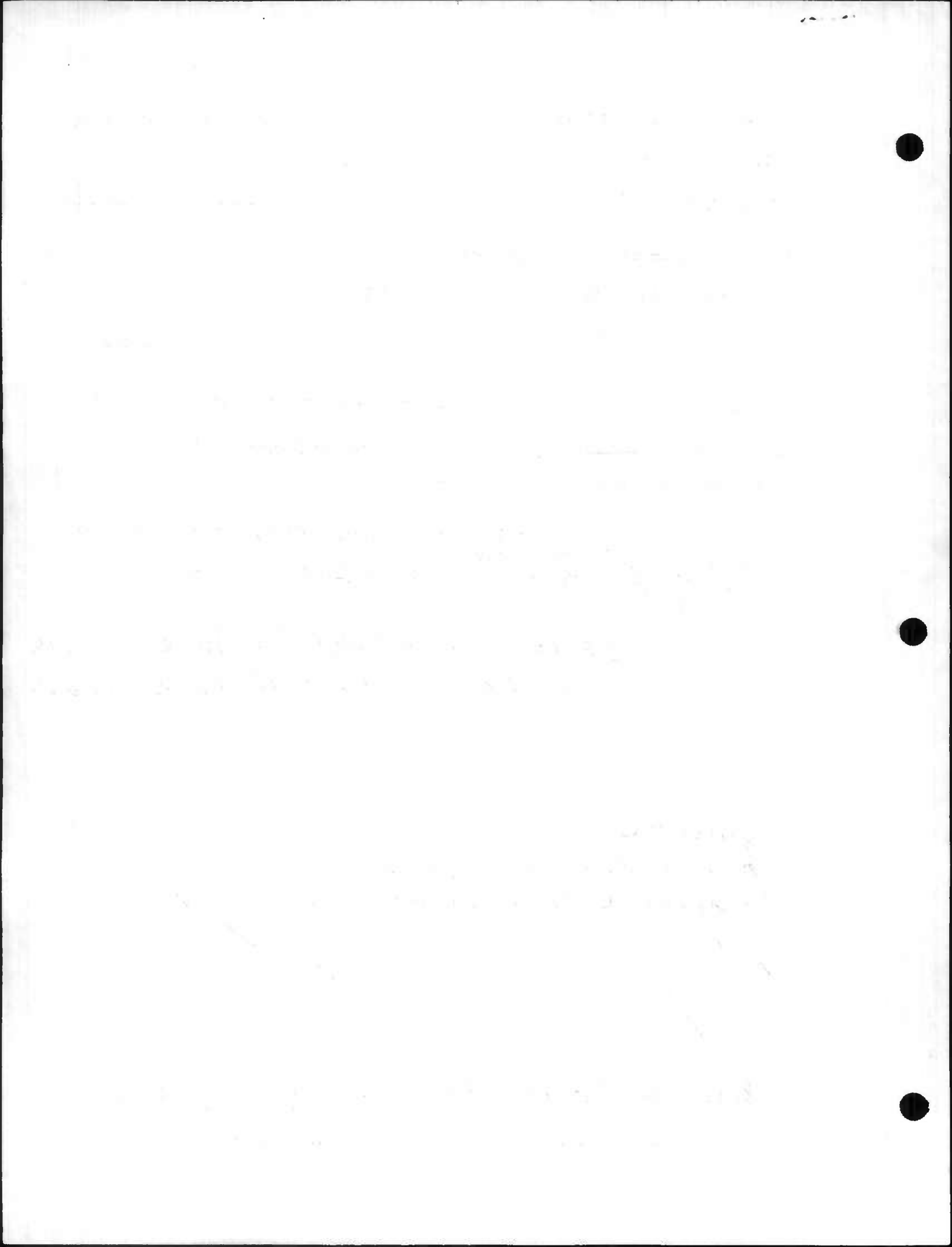
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The physician who certifies that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



AM
BRENDA
WILLIAMS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25162

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|---|---|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) BRENDA D. WILLIAMS | | | | 2. Date of Death Month Day Year AUGUST 14, 1997 | | 3. Time of Death 3:26 P | |
| | 4a. Facility Name (If not institution, give street and number) 4402 CHALET CT. APT. 2C | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 213-60-5807 | 6. Sex 1 <input type="checkbox"/> M 3 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 46 | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) JUL 25, 1951 | | 9. Birthplace (State or Foreign Country) MD |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | 10b. County N/A | 10c. City, Town or Location BALTO | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | 10e. Street and Number 4402 CHALET CT APT 2C | | | 10f. Zip Code 21206 | | 10g. Citizen of What Country? U.S.A. | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 11th N/A | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NURSING AID | | 16b. Kind of Business/Industry HOSPITAL | | | |
| | 17. Father's Name (First, Middle, Last) ALEXANDER ROSWELL | | | | 18. Mother's Name (First, Middle, Maiden Surname) VERNICE MONROE | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) VERNICE BURRELL | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2127 CLIFWOOD AVE BALTO, MD 21213 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) BALTIMORE CEM | | 20c. Location - City or Town, State BALTO, MD | | 20d. Date AUG 20 1997 | |
| | 21. Signature of Funeral Service Licensee Patricia Betts | | | 22. Name and Address of Facility BETTS FUNERAL HOME 1129 N. CAROLINE ST BALTO, MD 21213 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? INSPECTION 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Margarita Korell | | 29c. License number OCME | | 29d. Date signed (Month, Day, Year) AUGUST 15, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 20 1997 | | 32. Registrar's Signature Julia Davidson-Randall | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25163

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BARBARA WATERS

2. Date of Death

Month

Day

Year

3. Time of Death

August

17

1997

2300

4a. Facility Name (If not institution, give street and number)

Denton University Maryland Medicine

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

5. Social Security Number

220-30-1089

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

61

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

07-11-36

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

1102 Druid Hill Avenue

10f. Zip Code

21201

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th Grade

College (1-4 or 5+)

College Grad

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Full-time

16b. Kind of Business/Industry

S.S. Administration

17. Father's Name (First, Middle, Last)

Randolph

Nichols

18. Mother's Name (First, Middle, Maiden Surname)

Mildred

Smith

19a. Informant's Name/Relationship (Type, Print)

DeNiece Barger

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3231 Normount Avenue Baltimore, Maryland 21216

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Western Star Cemetery 08-21-97 Catonsville, Md.

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

James P. Richardson

22. Name and Address of Facility

Baltimore, Maryland 21202
WM.C. March FH 1101 E. North Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. STAPHYLOCOCCAL BACTELEMIA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 WEEKS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. PRESSURE SORES

Due to (or as a consequence of):

MONTHS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RENAL FAILURE

MALNUTRITION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient

28. Place of Death (Check only one)

3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

James P. Richardson

29c. License number

027394

29d. Date signed (Month, Day, Year)

8/19/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. James P. Richardson, MD

29 S. PACA ST. BALTO. MD 21201

31. Date filed (Month, Day, Year)

AUG 20 1997

32. Registrar's Signature

James P. Richardson

WATERS, BARBARA

Baltimore, Maryland 21215-0026

Permit: Pages 1 and 2 should be filed within 72 hours of death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 68760,

3

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 25164**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last) William Wayne Wolfe | | | | 2. Date of Death Month Aug Day 18 Year 1997 | | 3. Time of Death 2019 | |
| 4a. Facility Name (If not institution, give street and number) 251 Carvel Rd | | | | 4b. City, Town, or Location of Death Pasadena | | 4c. County of Death AA | |
| 5. Social Security Number 218-76-3790 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 40 Yrs. | | 8. Date of Birth (Month, Day, Year) March 31, 1957 | |
| 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Anne Arundel | | 10c. City, Town or Location Rivera Beach | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 251 Carvel Road | | 10f. Zip Code 21122 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) N/A | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Jeweler | | 16b. Kind of Business/Industry Self Employed | | | |
| 17. Father's Name (First, Middle, Last) Earl W. Wolfe | | | | 18. Mother's Name (First, Middle, Maiden Surname) Gladys M. Blankenship | | | |
| 19a. Informant's Name/Relationship (Type, Print) Gladys M. Wolfe Mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 207 Winston Road Pasadena, Maryland 21122 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery Aug. 21, 1997 | | 20c. Location - City or Town, State Baltimore, Maryland | | 21. Signature of Funeral Service Licensee [Signature] | |
| 22. Name and Address of Facility McCully-Polyniak Funeral Home 3204 Mountain Road Pasadena, Maryland 21122 | | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Gunshot Wound Head Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | Approximate Interval Between Onset and Death | |

To Be Completed by Funeral Director

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Gunshot Wound Head Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | Approximate Interval Between Onset and Death | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 8/18/97 | | 28b. Time of Injury UNKNOWN | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred Shot self | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) Pasadena, MD | | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier [Signature] Deputy MD | | 29c. License number D06054 | | 29d. Date signed (Month, Day, Year) 8/18/97 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William P. Jones, MD 1095 America Ct 21035 | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 20 1997 | | | | 32. Registrar's Signature [Signature] | | | |

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21268-0760. To the Medical Examiner: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25165

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Edward Anthony Winogrodzki

2. Date of Death

August 18 1997

Day Year

3. Time of Death

4:30 AM

4a. Facility Name (If not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

165-20-8117

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

November 1, 1926

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Rockdale

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3439 Gaither Road

10f. Zip Code

21244

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12 Years

College (1-4 or 5+)

3 Years

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Musician

16b. Kind of Business/Industry

Self Employed

17. Father's Name (First, Middle, Last)

Joseph Winogrodzki

18. Mother's Name (First, Middle, Maiden Surname)

Eva Sobolowski

19a. Informant's Name/Relationship (Type, Print)

Mrs. Margaret Winogrodzki

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3439 Gaither Road Baltimore, MD 21244

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Carroll Cremation Service 8/19/97

Date

20c. Location - City or Town, State

Hampstead, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Loring Byers Funeral Directors, Inc.
8728 Liberty Road Randallstown, MD 2113323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Streptococcal pneumonia

Approximate
Interval Between
Onset and Death

5 days.

Due to (or as a consequence of):

b. metastatic prostate cancer

6 years.

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypothyroidism

GI bleed due to erosive gastritis

Pancytopenia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 8 ☐ Could not be
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of
injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of Certifier

Dr. J. Popat, MD

29c. License number

AT 2438946

29d. Date signed (Month, Day, Year)

8/18/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vaishali Popat-Thakkar, MD.

201, East University Parkway
Baltimore, MD 21218

31. Date filed (Month, Day, Year)

AUG 20 1997

32. Registrar's Signature

John L. ...

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death. This certificate has been signed by the attending physician and
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in, the funeral director, page 2 should be detached for use as the burial-transit
document.

Division of Vital Records, P.O. Box 68760,

Winogrodzki, Edward

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25166

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Virginia N. Martin Atkinson

2. Date of Death

August 19, 1997

3. Time of Death

1:30am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

217-09-3227

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

December 12, 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Pasadena

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8553 Summit Road

10f. Zip Code

21122

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

9

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Nursing Assistant

16b. Kind of Business/Industry

Home Care Service

17. Father's Name (First, Middle, Last)

Martin

18. Mother's Name (First, Middle, Maiden Surname)

Henrietta Smith

19a. Informant's Name/Relationship (Type, Print)

Robert W. Atkinson/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8553 Summit Road, Pasadena, MD 21122

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Hillcrest Cemetery

Date

Aug. 22 Federalsburg, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Stallings Funeral Home, P.A.
3111 Mountain Road, Pasadena, Maryland 2112223a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

e. RESPIRATORY FAILURE

Due to (or as a consequence of):

b. ALZHEIMERS DISEASE

Due to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

c. ASPIRATION PNEUMONIA

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of causa
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

MD D45149

29d. Date signed (Month, Day, Year)

August 19 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ONABAYO, B 301 HOSPITAL DRIVE GLEN BURNIE MD 21061

31. Date filed (Month, Day, Year)

AUG 21 1997

32. Registrar's Signature

[Signature]

State
RegistrarBaltimore, Maryland 21215-0020
perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25167

Certificate of Death

Reg. No.

| | | | | | |
|--|---|--|---|---|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) James Broadway Jr. | | 2. Date of Death Month August Day 17 Year 1997 | | 3. Time of Death 19:22 |
| | 4e. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | 4b. City, Town, or Location of Death BALTIMORE CITY | | 4c. County of Death N/A |
| Funeral Director | 5. Social Security Number 215-01-6918 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 86 Yrs. | 8. Date of Birth (Month, Day, Year) MAR. 27, 1911 | |
| | 9. Birthplace (State or Foreign Country) NORTH CAROLINA | | Usual Residence of Decedent | | |
| To Be Completed by Funeral Director | 10a. State MARYLAND | 10b. County N/A | 10c. City, Town or Location BALTIMORE CITY | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number 2712 E. PRESTON STREET | | 10f. Zip Code 21213 | | 10g. Citizen of What Country? U.S.A. |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: NEGRO | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8TH College (1-4 or 5+) N/A | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ICE MAKER | | 16b. Kind of Business/Industry ICE CO. | | |
| | 17. Father's Name (First, Middle, Last) JAMES BROADWAY, SR. | | 18. Mother's Name (First, Middle, Maiden Surname) ETHEL CARTER | | |
| | 19e. Informant's Name/Relationship (Type, Print) CLARA BROADWAY | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2712 E. PRESTON ST. BALTIMORE, MD. 21213 | | |
| | 20e. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other: ENTOMBMENT | | 20b. Place of Disposition (Name of cemetery, crematory or other place) ARBUTUS MEMORIAL PARK | | 20c. Location - City or Town, State AUG. 21, 1997 BALTO, MD. |
| | 21. Signature of Funeral Service Licensee <i>Calvin B. Scruggs</i> | | 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213 | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | |
| Physician /Medical Examiner | Immediate Cause (Final disease or condition resulting in death) e. metastatic gastric adenocarcinoma Due to (or as a consequence of): b. anorexia Due to (or as a consequence of): c. prostate cancer Due to (or as a consequence of): d. _____ | | | | Approximate Interval Between Onset and Death 1 year 6 weeks 1 year |
| | Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | |
| | 24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M |
| | 28c. Injury of Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how Injury occurred | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | 29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | |
| 29b. Signature and title of certifier Aubrie C. Jacobson, MD | | 29c. License number RES-000 | | 29d. Date signed (Month, Day, Year) August 17, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Aubrie C. Jacobson, MD, Tower 110, Johns Hopkins Hospital | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) AUG 21 1997 | | 32. Registrar's Signature <i>Jenna Davidson-Randall</i> | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25168

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|--|--|---|--|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Ruby Lee Brophy | | | | 2. Date of Death Month August Day 15 Year 1997 | | 3. Time of Death 2240 | | |
| | 4a. Facility Name (If not institution, give street and number) University of Maryland Medical System | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | | |
| Funeral Director | 5. Social Security Number 214 50 1765 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 50 Yrs. | | 8. Date of Birth (Month, Day, Year) Jan. 20, 1947 | | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Anne Arundel | | 10c. City, Town or Location Odenton | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number 2006 Peaceful Way Apt. 102 | | | | |
| | 10f. Zip Code 21113 | | | | 10g. Citizen of What Country? U.S. | | | | |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 years | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Budget Assistant | | 16b. Kind of Business/Industry U. S. Government Dept. Health & Human | | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Emmett Milby | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mildred Walters | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Richard R. Brophy Jr. / husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2006 Peaceful Way Apt. 102 Odenton, Md. 21113 | | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Crestlawn Cemetery | | Date 8/19/97 | | 20c. Location - City or Town, State Marriottsville, Md. | | |
| | 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 | | | | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Mucormycosis Due to (or as a consequence of): b. Wegener's Granulomatosis Due to (or as a consequence of): c. Diabetes Mellitus Due to (or as a consequence of): d. Renal Failure Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death 1.5 months 5 years | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | 29b. Signature and title of certifier  | |
| | 29c. License number P10367 | | 29d. Date signed (Month, Day, Year) August 15, 1997 | | | | | | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Jeffrey S. Wolf, M.D. 22 S. Greene Street Baltimore, Md. 21201 | | | | | | | 31. Date filed (Month, Day, Year) AUG 21 1997 | |
| | 32. Registrar's Signature  | | | | | | | 33. State Registrar AUG 21 1997 | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25169

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|--|---|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Cora Bolender | | | | 2. Date of Death Month Day Year August 15 1997 | | | | 3. Time of Death 7:20 Am | |
| | 4a. Facility Name (If not institution, give street and number) 817 Camp meade Rd. | | | | 4b. City, Town, or Location of Death Linthicum | | | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 285-14-6166 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 81 Yrs. | | 8. Date of Birth (Month, Day, Year) 9/16/1915 | | 9. Birthplace (State or Foreign Country) Michigan | |
| | Usual Residence of Decedent | | | | 10a. State MD. | | 10b. County Anne Arundel | | 10c. City, Town or Location Pasadena | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 10e. Street and Number 1889 Poplar Ridge Rd. | | 10f. Zip Code 21122 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: white | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker | | | 16b. Kind of Business/Industry own home | | | | |
| | 17. Father's Name (First, Middle, Last) Oliver K. Isanhart | | | | 18. Mother's Name (First, Middle, Maiden Surname) Lena Bingman | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Martha M. Russell, daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1889 Poplar Ridge Rd., Pasadena, Md. 21122 | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Crestlawn Memorial Gardens | | Date 8/18/97 | | 20c. Location - City or Town, State Marriottsville, Md. | | | |
| | 21. Signature of Funeral Service Licensee <i>R. Gray Witzke</i> | | | | 22. Name and Address of Facility Witzke Funeral Homes, Inc. 1630 Edmondson Ave., Catonsville, Md. 21228 | | | | Approximate Interval Between Onset and Death | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Adenocarcinoma of Lung Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice | | | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28e. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| | 29b. Signature and title of certifier <i>Dianna A. GRIFFITH</i> | | | | 29c. License number D 19419 | | | | 29d. Date signed (Month, Day, Year) August 15, 1997 | |
| | 30. Name and address of person who completed cause of death (from 23a) (Type, Print) DIANNA A. GRIFFITH 6900 CATON AVE BALTIMORE MD 21229 | | | | | | | | | |
| | 31. Date filed (Month, Day, Year) AUG 21 1997 | | 32. Registrar's Signature <i>John Davidson-Randell</i> | | | | | | | |
| | 33. Date of Death (Month, Day, Year) August 15, 1997 | | | | | | | | | |
| | 34. Date of Birth (Month, Day, Year) 9/16/1915 | | | | | | | | | |
| | 35. Date of Death (Month, Day, Year) August 15, 1997 | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25170

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Phyllis A. Bak | | | | 2. Date of Death Month August Day 16 Year 1997 | | 3. Time of Death 2:00AM | |
| 4a. Facility Name (If not institution, give street and number) 32 Edelweiss Way | | | | 4b. City, Town, or Location of Death Parkton | | 4c. County of Death Baltimore | |
| 5. Social Security Number 020-18-4021 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 77 Yrs. | | 8. Date of Birth (Month, Day, Year) April 18, 1920 | |
| Usual Residence of Decedent | | | | 9. Birthplace (State or Foreign Country) Massachusetts | | | |
| 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Parkton | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 32 Edelweiss Way | | | | 10f. Zip Code 21120 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) 12 yrs Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) agent | | 16b. Kind of Business/Industry Real estate | |
| 17. Father's Name (First, Middle, Last) Charles Juskiewicz | | | | 18. Mother's Name (First, Middle, Maiden Surname) Anna Guzowska | | | |
| 19a. Informant's Name/Relationship (Type, Print) Millicent E. Romero | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32 Edelweiss Way Parkton, Md 21120 | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Cemetery | | 20c. Location - City or Town, State Baltimore Maryland | | 20d. Date Aug 18 1997 | |
| 21. Signature of Funeral Service Licensee Krista S. Wells | | | | 22. Name and Address of Facility Evans Chapel of Chimes 2325 York Rd. Timonium, Maryland 21093 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| Immediate Cause (Final disease or condition resulting in death) a. Shy-Drager Syndrome Due to (or as a consequence of): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): | | | | | | | |
| c. Due to (or as a consequence of): | | | | | | | |
| d. Due to (or as a consequence of): | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier Norman Anderson | | | | 29c. License number D16101 | | 29d. Date signed (Month, Day, Year) 18 Aug 97 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Norman Anderson 601 N. Caroline St. Baltimore, Md 21287 | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 21 1997 | | | | 32. Registrar's Signature Jill Davidson-Randall | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

T

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25171

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Maryland Barnes

2. Date of Death

Month 08 Day 17 Year 97

3. Time of Death

10:59am

4a. Facility Name (If not institution, give street and number)

Greenspring Nursing & Rehab Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

217-26-4184

6. Sex

M

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 30, 1921

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

2128 W. FAYETTE STREET

10f. Zip Code

21223

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever In U.S.

Armed Forces?
1 Yes 2 No
If Yes, Give Year or Dates: DISCHARGE 12-12-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
8th GRADE

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

WELDER

16b. Kind of Business/Industry

UNITED BOSTON STEEL

17. Father's Name (First, Middle, Last)

LUKE BARNES

18. Mother's Name (First, Middle, Maiden Surname)

MABEL DAVIS

19a. Informant's Name/Relationship (Type, Print)

HAYES BARNES (BROTHER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

706 N. HILTON STREET, BALTIMORE, MD. 21229

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT. ZION CEMETERY

Date

8-22-97 BALTIMORE, MARYLAND

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Sharon D. Boykin

22. Name and Address of Facility

JOSEPH H. BROWN JR. FUNERAL HOME
2140 N. FULTON AVE., BALTO. MD. 21217

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. CHRONIC RENAL FAILURE

Approximate Interval Between Onset and Death

MONTHS

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CANCER OF THE TONGUE

MONTHS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide
5 Pending Investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

B. C. Veneracion Jr. M.D.P.A.

29c. License number

D13664

29d. Date signed (Month, Day, Year)

Aug 18, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

B. C. VENERACION JR. M.D.P.A. 1576 MERRITT BLVD, BALTO. MD 21222

31. Date filed (Month, Day, Year)

AUG 21 1997

32. Registrar's Signature

Julian Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25172

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Charles W. Brooks

2. Date of Death

Month Day Year
Aug 13, 1997

3. Time of Death

2:47 pm

4a. Facility Name (If not institution, give street and number)

727 Druid Park Lake Drive

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

217-26-6495

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

66

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan 6, 1931

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

727 Druid Park Lake Drive

10f. Zip Code

21217

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married2 ☒ Married3 ☐ Widowed4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Trucker

16b. Kind of Business/Industry

Brass & Copper Co

17. Father's Name (First, Middle, Last)

unk

18. Mother's Name (First, Middle, Maiden Surname)

unk

19a. Informant's Name/Relationship (Type, Print)

Bruce Brooks (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

311 Dover Dr., Andrews AFB, Maryland 20762

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Druid Ridge Cemetery

Date

8/19/97 Baltimore, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

A. Alan Seitz, Jr.

22. Name and Address of Facility

A. Alan Seitz, Jr. Funeral Home
3818 Roland Avenue, Baltimore, Md 21211

23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive heart failure complications

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Ischemic Cardiomyopathy

Due to (or as a consequence of):

4 years

c. Coronary artery disease

Due to (or as a consequence of):

4 years

Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

Severe chronic obstructive lung disease

Severe gastritis

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

A. Alan Seitz, Jr. MD

29c. License number

AT 2438946

29d. Date signed (Month, Day, Year)

8-18-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

201 East University Pkwy-Baltimore, MD- Maria H.F. Onuchic, MD

31. Date filed (Month, Day, Year)

AUG 21 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of vital records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25173

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|---|--|---|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Bok Sun Chun | | | | 2. Date of Death Month Day Year August 18 1997 | | 3. Time of Death 10:15 p.m. | | |
| | 4a. Facility Name (If not institution, give street and number) Bayview Medical Center | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | | |
| Funeral Director | 5. Social Security Number 215-31-3577 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 68 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth Month Day Year 7-24-1929 | 9. Birthplace (State or Foreign Country) Korea | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | 10e. Street and Number 2000 Odell Ave. Apt. 714 | | | | 10f. Zip Code 21237 | | 10g. Citizen of What Country? USA | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Korean | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | | | | |
| | 17. Father's Name (First, Middle, Last) Sung Ho Lee | | | | 18. Mother's Name (First, Middle, Maiden Surname) Saun Chen | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) (Husband) Mr. Byong Joon Chun | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2000 Odell Ave. Apt. 714 Balto. Md. 21237 | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hills Mem. Park | | 20c. Location - City or Town, State Middle River, Md. | | 20d. Date 8/21/97 | | |
| | 21. Signature of Funeral Service Licensee Joseph L. Russ | | | | 22. Name and Address of Facility Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Michael Polydefkis MD | | 29c. License number L5176 | | 29d. Date signed (Month, Day, Year) August 19, 1997 | | 29e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Michael Polydefkis, MD Johns Hopkins Hospital Baltimore MD 21287 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 21 1997 | | | | | | | | | |
| 32. Registrar's Signature John Davidson-Randall | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Probable sepsis

Junctional tachycardia

Certificate of Death

Reg. No.

97 25174

| | | | | | | | |
|--|---|---|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ANTONIO MAURICE CARR | | | 2. Date of Death Month AUGUST Day 18 Year 1997 | | 3. Time of Death 2325 E | |
| | 4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL ER | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death na | |
| Funeral Director | 5. Social Security Number 220-92-4336 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 18 Yrs. | 8. Date of Birth (Month, Day, Year) SEPT. 15, 1978 | 9. Birthplace (State or Foreign Country) BALTIMORE, MD | |
| | Usual Residence of Decedent: 10a. State MD 10b. County na 10c. City, Town or Location BALTIMORE | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 10e. Street and Number 5105 QUEENBERRY AVENUE | | 10f. Zip Code 21215 | | 10g. Citizen of What Country? UNITED STATES | | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 th College (1-4 or 5+) - | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEKEEPING | | 16b. Kind of Business/Industry ST. JOSEPH HOSPITAL | | | |
| 17. Father's Name (First, Middle, Last) TAVON M. CARR | | | 18. Mother's Name (First, Middle, Maiden Surname) LAVONNE BYRD | | | | |
| 19a. Informant's Name/Relationship (Type, Print) (mother) LAVONNE MICHELLE BYRD | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5107 QUEENBERRY AVENUE, BALTIMORE, MD #15 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) WOODLAWN CEMETERY | | 20c. Location - City or Town, State 8-25-97 BALTIMORE, MD | | | |
| 21. Signature of Funeral Service Licensee <i>Glynn B. Harris</i> | | 22. Name and Address of Facility WM. C. MARCH FH.-4300 WABASH AVENUE | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <i>Multiple gunshot wounds</i> Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide | | 28a. Date of injury (Month, Day, Year) 8/18/97 | | 28b. Time of injury 2351 HX | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) street | | 28d. Describe how injury occurred Subject shot | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>Theodore M. King</i> | | 29c. License number O.C.M.E | | 29d. Date signed (Month, Day, Year) AUGUST 19, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODORE M. KING | | 31. Date filed (Month, Day, Year) AUG 21 1997 | | | | | |
| 31. Date filed (Month, Day, Year) AUG 21 1997 | | Registrar's Signature <i>John Davidson-Randall</i> | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

3
State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25175

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Stanley Charles Cronise | | | | 2. Date of Death Month August Day 20 Year 1997 | | 3. Time of Death 1:15 P.M. | |
| | 4a. Facility Name (If not institution, give street and number) 1170 River Bay Road | | | | 4b. City, Town, or Location of Death Annapolis | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 218 09 2524 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 78 Yrs. | | 8. Date of Birth (Month, Day, Year) August 21, 1918 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Anne Arundel | | 10c. City, Town or Location Annapolis | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number 1170 River Bay Road | | 10f. Zip Code 21401 | |
| | 10g. Citizen of What Country? U.S. | | | | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Supervisor | | | | 16b. Kind of Business/Industry Bethlehem Steel | | 17. Father's Name (First, Middle, Last) Raymond Charles Cronise | |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Surname) Edith Wilkinson | | | | 19a. Informant's Name/Relationship (Type, Print) LaVelle Siefert / daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1170 River Bay Road Annapolis, Maryland 21401 | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp. | | 20c. Location - City or Town, State 8/23/97 Towson, Maryland | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 | | | |
| | 23a. Part I. Enter the disease or diseases that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE MYELOGENOUS LEUKEMIA - REFRACTORY Due to (or as a consequence of): b. LEFT UPPER LOBE PNEUMONIA Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death 24 Months 1 Month | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) M 28b. Time of Injury 1 Yes <input type="checkbox"/> No 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier Joseph A. Fontana, Professor of Medicine | | | |
| | 29c. License number D34917 | | | | 29d. Date signed (Month, Day, Year) 8/21/1997 | | | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph A Fontana, University of Maryland Hospital 225 GREENE ST, Baltimore, Maryland 21201 | | | | 31. Date filed (Month, Day, Year) AUG 21 1997 | | | |
| | 32. Registrar's Signature  | | | | 33. Date of Death 10 | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25176

DARNELL LAWSON

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|---|---|---------------------------|---|--|---|--|---|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) DONNELL LAWSON DOOSE | | | | | | 2. Date of Death Month Day Year AUGUST 13 1997 | | 3. Time of Death 10:08 PM | | |
| | 4a. Facility Name (If not institution, give street and number) 1800 BLOCK OF N. CHAPEL STREET | | | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death | | |
| Funeral Director | 5. Social Security Number 217-92-9379 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs., last birthday) 16 Yrs. | | 8. Date of Birth (Month, Day, Year) SEP 9, 1978 | | 9. Birthplace (State or Foreign Country) MARYLAND | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 10e. Street and Number 1535 N. WASHINGTON ST. | | | | 10f. Zip Code 21213 | | 10g. Citizen of What Country? U.S.A | | | | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10TH College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) N/A | | | | 16b. Kind of Business/Industry N/A | | | |
| 17. Father's Name (First, Middle, Last) EUGENE DOOSE | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) FLORENCE LAWSON | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) EUGENE DOOSE | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2053 E. MONUMENT ST. BALTIMORE, MD 21205 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) VOSCHER Cem. | | 20c. Location - City or Town, State BALTIMORE MD | | 20d. Date 8/20/97 | | | |
| 21. Signature of Funeral Service Licensee | | | | | | 22. Name and Address of Facility 270 FREDERICK PASS BALTIMORE, MD 21224 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MULTIPLE GUNSHOT WOUNDS Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE | | | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) 9-13-97 | | 28b. Time of Injury 2204 M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred SURFISER SHOT | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) STREET | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1800 BLOCK N CHAPEL ST BALTIMORE MD | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) AUGUST 14, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H. D. G. and D. A. K. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 21 1997 | | | | 32. Registrar's Signature | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25177

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Edward Phillip Dopko | | | | 2. Date of Death Month: Aug. Day: 16 Year: 1997 | | 3. Time of Death 7:30 PM | |
| | 4a. Facility Name (If not Institution, give street and number) 5512 Sleeping Dog Lane | | | | 4b. City, Town, or Location of Death Columbia | | 4c. County of Death Howard | |
| Funeral Director | 5. Social Security Number 178-22-5771 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 68 Yrs. | | 8. Date of Birth (Month, Day, Year) Apr. 30, 1929 | |
| | 10a. State MD | | 10b. County Howard | | 10c. City, Town or Location Columbia | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Funeral Director | 10e. Street and Number 5512 Sleeping Dog Lane | | | | 10f. Zip Code 21045 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanic | | 16b. Kind of Business/Industry Horse Farm | | | |
| | 17. Father's Name (First, Middle, Last) Anthony V. Dopko | | | | 18. Mother's Name (First, Middle, Maiden Surname) Kathryn A. Zielinski | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Philip Dopkowski (Brother) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5512 Sleeping Dog Lane, Columbia, MD 21045 | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Mary's Cemetery | | 20c. Location - City or Town, State Plymouth, PA | | 20d. Date Aug. 21, 1997 | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Rd. Columbia, MD 21045 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC BLADDER CANCER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 6+1 | 29b. Signature and title of certifier Nicholas Koutrelakis MD | | | | 29c. License number D38509 | | 29d. Date signed (Month, Day, Year) August 18th 1997 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NICHOLAS KOUTRELAKIS MD 11065 Little Patuxent Pkwy Columbia MD 21044 | | | | | | | |
| Physician /Medical Examiner | 31. Date filed (Month, Day, Year) AUG 21 1997 | | | | 32. Registrar's Signature  | | | |
| | State Registrar | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

T



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25178
Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|---|---|--|--|--|--------------------------------------|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) NICHOLAS WILLIAM DUBBS | | | | 2. Date of Death Month Day Year AUG 17 1997 | | 3. Time of Death 1812 | |
| | 4a. Facility Name (If not institution, give street and number) Howard County General Hospital | | | | 4b. City, Town, or Location of Death Columbia | | 4c. County of Death Howard | |
| Funeral Director | 5. Social Security Number N/A | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) Yrs. 4 | If Under 1 Year Months 4 Days | If Under 24 Hrs. Hours 4 Min. | 8. Date of Birth (Month, Day, Year) AUG. 13, 1997 | | 9. Birthplace (State or Foreign Country) MD |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County BALTIMORE | | 10c. City, Town or Location REISTERSTOWN | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 37 BLACK OAK COURT | | | | 10f. Zip Code 21136 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 Collega (1-4or 5+) N/A | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) N/A | | 16b. Kind of Business/Industry N/A | | |
| 17. Father's Name (First, Middle, Last) MITCHELL LOUIS DUBBS | | | | 18. Mother's Name (First, Middle, Maiden Summa) REBECCA SHIVELY | | | | |
| 19a. Informant's Name/Relationship (Type, Print) MITCHELL DUBBS (FATHER) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 37 BLACK OAK COURT REISTERSTOWN MARYLAND 21136 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) COLUMBIA MEM. PARK | | 20c. Location - City or Town, State 8/20/97 COLUMBIA MARYLAND | | 21. Signature of Funeral Service Licensee | | |
| 22. Name and Address of Facility WITZKE FUNERAL HOME OF CATONSVILLE, INC. 1630 EDMONDSON AVENUE CATONSVILLE MARYLAND 21228 | | | | 23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SEVERE INTRAUTERINE GROWTH RETARDATION Due to (or as a consequence of): b. PREMATURITY Due to (or as a consequence of): c. SEPSIS Due to (or as a consequence of): d. PERSISTENT PULMONARY HYPERTENSION OF THE NEWBORN Approximate Interval Between Onset and Death 4 DAYS 4 DAYS 4 DAYS 4 DAYS | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | |
| 28a. Date of Injury (Month, Day, Year) | | | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number D39917 | | 29d. Date signed (Month, Day, Year) AUG 17 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GARY BLECHMAN M.D. : 5755 CEDAR LANE, COLUMBIA, MARYLAND 21044 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 21 1997 | | | | 32. Registrar's Signature | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

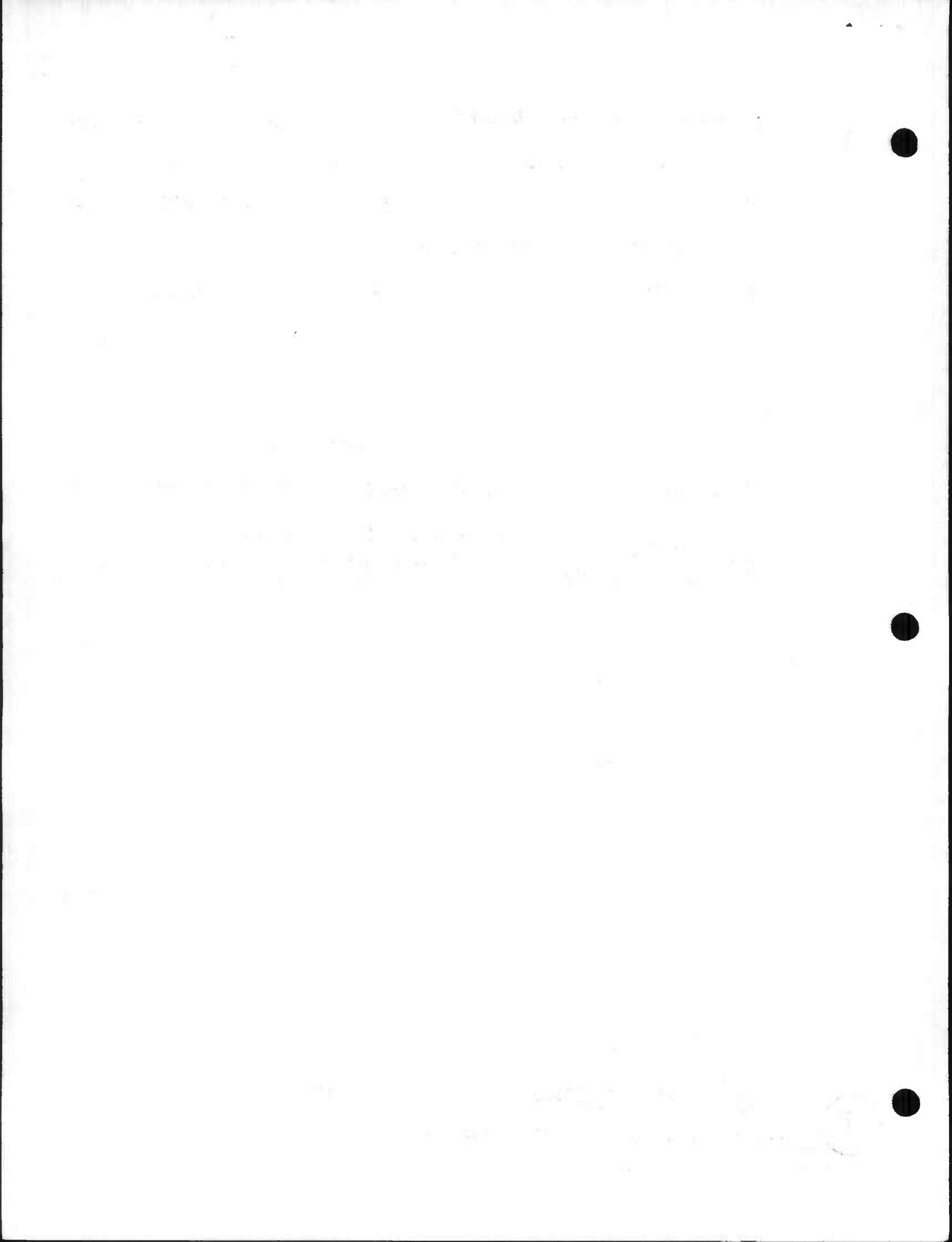
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 25179**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Anne T. Durase

2. Date of Death

Month Day Year
August 17 1997

3. Time of Death

3:15 PM

4a. Facility Name (If not institution, give street and number)

5231 Castlestone Dr.

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

094-05-3388

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
July 27 1918

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Rosedale

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5231 Castlestone Dr.

10f. Zip Code

21237

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12 yrs.

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

administrative assistant

16b. Kind of Business/Industry

Villa Julie College

17. Father's Name (First, Middle, Last)

Michael Mainelli

18. Mother's Name (First, Middle, Maiden Surname)

Benedetta DiJulio

19a. Informant's Name/Relationship (Type, Print)

Bertha Anne Durase

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5231 Castlestone Dr. Rosedale, Maryland 21237

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Memorial Garden

Date

Aug 20

20c. Location (City or Town, State)

Timonium, Maryland

21. Signature of Funeral Service Licensee

Krista S. Wells

22. Name and Address of Facility

Evans Chapel of Chimes
2325 York Rd. Timonium, Maryland 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

metastatic squamous CA anus

Approximate Interval Between Onset and Death

3y

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Serious Arthritis
CLL

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

R. Huslig MD

29c. License number

D36814

29d. Date signed (Month, Day, Year)

8/18/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. R. Huslig 7305 Astor Drive Suite 504 Towson, Md. 21204

31. Date filed (Month, Day, Year)

AUG 21 1997

32. Registrar's Signature

Julia Davidson-Randall

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

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97 25180

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97 25181

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Zelda M. Forrest | | | | 2. DATE OF DEATH MONTH DAY YEAR August 17, 1997 | | 3. TIME OF DEATH 2:33 P.M. | |
| 4. SOCIAL SECURITY NUMBER 578-56-4355 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 65 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) July 31, 1932 | |
| 8. BIRTHPLACE (State or Foreign Country) Washington, D.C. | | | | 9a. FACILITY NAME (If not institution, give street and number) Prince Georges Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Cheverly | |
| 9c. COUNTY OF DEATH P.G. | | | | RESIDENCE OF DECEDENT | | | |
| 10a. STATE N/A | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION Washington, D.C. | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 811 21th ST. N.E. | | | | 10f. ZIP CODE 20002 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 5+) 12 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Mail Clerk | | 16b. KIND OF BUSINESS/INDUSTRY Government Printing | |
| 17. FATHER'S NAME (First, Middle, Last) Henry Forrest | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Alberta Shorter | | | |
| 19a. INFORMANT'S NAME (Type/Print) Samuel Forrest | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4416 Lee St., N.E. Wash. D.C. 20019 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery | | 20c. LOCATION — City or Town, State 8-22-97 Bladensburg, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Sharon Johnson-Salley | | | | 22. NAME AND ADDRESS OF FACILITY Capitol Mortuary 1425 Maryland Ave., N.E. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. CARDIOPULMONARY ARREST DUE TO (OR AS A CONSEQUENCE OF): | | | | Approximate Interval Between Onset and Death | |
| | | b. MYELOPROLIFERATIVE SYNDROME DUE TO (OR AS A CONSEQUENCE OF): | | | | 8 1/2 YRS | |
| | | c. POLYCYTHEMIA VERA DUE TO (OR AS A CONSEQUENCE OF): | | | | 8 1/2 YRS | |
| | | d. THROMBOCYTHEMIA | | | | 8 1/2 YRS. | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 6 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] | | | | 29c. LICENSE NUMBER D-26782 | | 29d. DATE SIGNED (Month, Day, Year) Aug. 18, 1997 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dal Yoo M.D. 1160 Varnum St., N.E. Wash. D.C. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) AUG 21 1997 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Rendell | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25182

Item 23a,b per PHY fil G75D 8-21-97 rja

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | |
|---|---|------------------------|---|---|--|--|--------------------------------|--|--|---|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) LELIA FLEENOR | | | | 2. Date of Death Month Day Year July 17, 1997 | | | | 3. Time of Death 6:10 AM | | | | | |
| | 4a. Facility Name (If not institution, give street and number) 6670 Palmer Mill Road | | | | 4b. City, Town, or Location of Death Williamsburg | | | | 4c. County of Death Hurlock | | | | | |
| Funeral Director | 5. Social Security Number 280-30-1617 | | 8. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 89 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | | 8. Date of Birth (Month, Day, Year) June 9, 1908 | | 9. Birthplace (State or Foreign Country) Virginia | |
| | Usual Residence of Decedent | | | | | | | | | | | | | |
| 10a. State Maryland | | 10b. County Hurlock | | 10c. City, Town or Location Williamsburg | | | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | |
| 10e. Street and Number 6670 Palmer Mill Road | | | | | | 10f. Zip Code 21643 | | | | 10g. Citizen of What Country? U.S.A. | | | | |
| 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4or 5+) 10 0 | | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | | 16b. Kind of Business/Industry Someone Else's Home | | | | |
| 17. Father's Name (First, Middle, Last) L. C. Crowder | | | | | | 18. Mother's Name (First, Middle, Maiden Summa) Pearl Clark | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Harold Crowder/brother | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 212 W. Arundel Road, Baltimore, Maryland 21225 | | | | | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Date | | | | 20c. Location - City or Town, State | | | | | | |
| 21. Signature of Funeral Service Licensee Ronald S. Wade, Director | | | | | | 22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201 | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CVA CEREBRO VASCULAR ACCIDENT Due to (or as a consequence of): b. ASCVD ARTERIO SCLORATIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | | | Approximate Interval Between Onset and Death 2 weeks | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypothyroid Arthritis CHF | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier J. Davidson D.O. | | | | 29c. License number 1.44615 | | | | 29d. Date signed (Month, Day, Year) 7/24/97 | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Lois L. Nass D.O., 215 Bloomingdale Ave. Fed. mo 21632 | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 21 1997 | | | | 32. Registrar's Signature J. Davidson-Randall | | | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

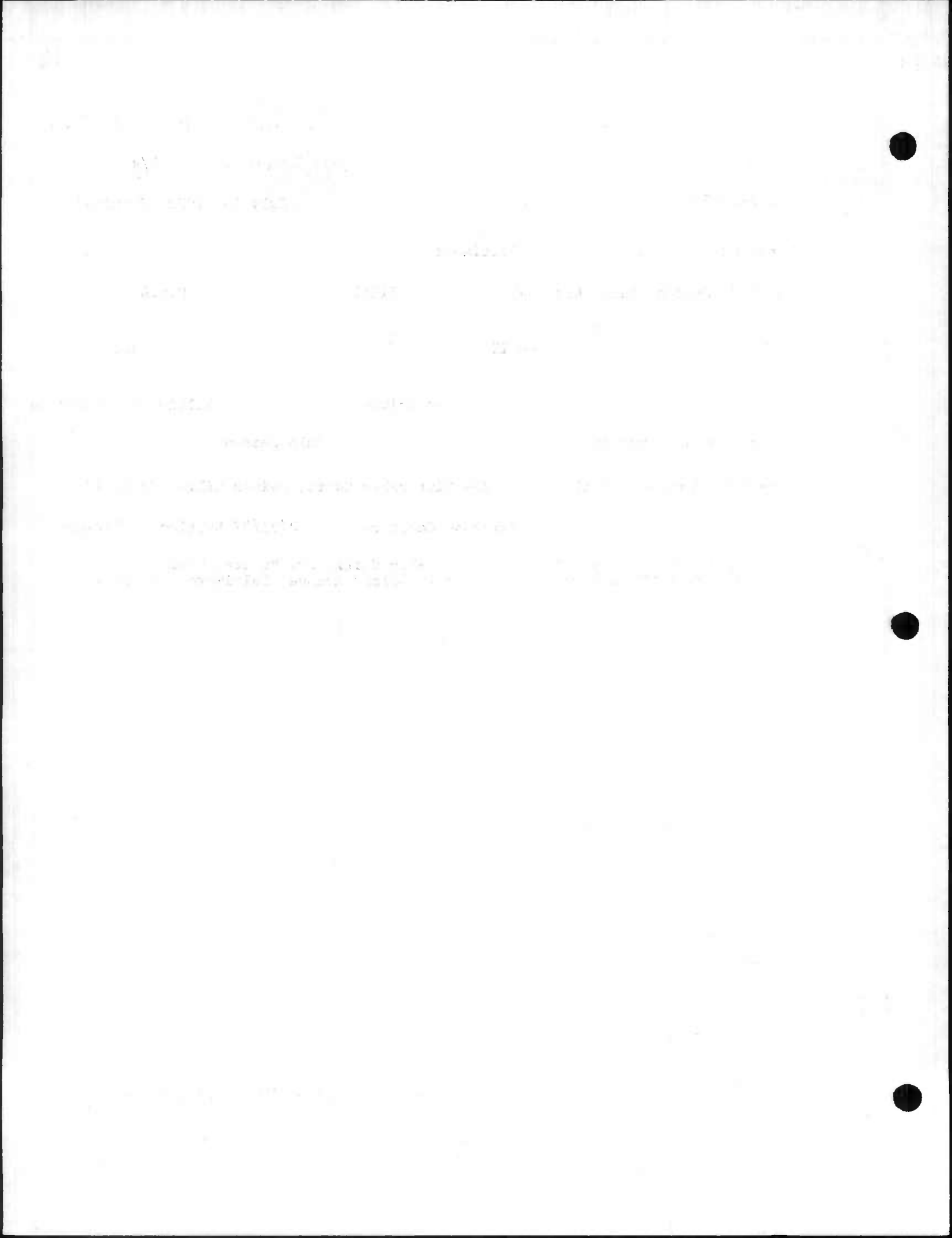
State of Maryland / Department of Health and Mental Hygiene

97 25183

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) FRANK H. FERGUSON | | | | 2. Date of Death Month AUGUST Day 18 Year 1997 | | 3. Time of Death 1729 | |
| | 4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 218-12-7960 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 74 Yrs. | | 8. Date of Birth (Month, Day, Year) July 10, 1923 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10. Usual Residence of Decedent 10a. State Maryland 10b. County N/A 10c. City, Town or Location Baltimore 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II | |
| To Be Completed by Funeral Director | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collega (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bus Driver | |
| | 16b. Kind of Business/Industry Baltimore Transit Co | | 17. Father's Name (First, Middle, Last) Arch Graham Ferguson | | 18. Mother's Name (First, Middle, Maiden Surname) Eula Jessee | | 19. Informant's Name/Relationship (Type, Print) Frank G. Ferguson (Son) | |
| Physician /Medical Examiner | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery | | 20c. Location - City or Town, State Baltimore, Maryland | | 20d. Date 8/21/97 | |
| | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility A. Alan Seitz, Jr. Funeral Home 3818 Roland Avenue, Baltimore, Md 21211 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. seizure disorder | | Approximate Interval Between Onset and Death | |
| Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Aortic stenosis, hypertension, peripheral vascular disease, end stage renal disease, polycythemia vera | | 23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| | 29b. Signature and title of certifier Ellie G. Cohen MD | | 29c. License number AS2402321-EC9008 | | 29d. Date signed (Month, Day, Year) August 18, 1997 | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Ellie G. Cohen, MD Sinai Hospital Baltimore, MD | |
| State Registrar | 31. Date filed (Month, Day, Year) AUG 21 1997 | | 32. Registrar's Signature | | 33. Date of Death (Month, Day, Year) AUGUST 18, 1997 | | 34. Time of Death 1729 | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25184

Item:4a per MD G-750 8/21/97 dh

Certificate of Death

Reg. No.

| | | | | | | | |
|---|--|---|--|--|--------------------------------|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ALFRED SMITH GORDON | | | 2. Date of Death Month AUGUST Day 13 Year 1997 | | 3. Time of Death 1900 | |
| | 4a. Facility Name (If not institution, give street and number) 745 MOORING ROAD - UNIT 102 | | | 4b. City, Town, or Location of Death OCEAN CITY | | 4c. County of Death WORCESTER | |
| Funeral Director | 5. Social Security Number 038-12-7343 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 69 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 6-28-28 |
| | 9. Birthplace (State or Foreign Country) NEW YORK | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County WORCESTER | | 10c. City, Town or Location OCEAN CITY | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 745 MOORING ROAD - UNIT 102 | | | | 10f. Zip Code 21842 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: WW II KOREAN | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 YRS College (1-4or 5+) 4 YRS | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LOAN OFFICER | | 16b. Kind of Business/Industry SMALL BUSINESS ADMINISTRATION | |
| 17. Father's Name (First, Middle, Last) JOSEPH RAYMOND GORDON | | | | 18. Mother's Name (First, Middle, Maiden Surname) HELEN MCGILLIVARY | | | |
| 19a. Informant's Name/Relationship (Type, Print) DIANE G. MATHERS (DAUGHTER) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7417 JEFFERSON STREET - HYATTSVILLE, MD 20784 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) OUR LADY OF VICTORY CHURCH | | Date 8/18/97 | | 20c. Location - City or Town, State BALTIMORE | |
| 21. Signature of Funeral Service Licensee <i>Jackie D. Shannon</i> | | | | 22. Name and Address of Facility HUBBARD FUNERAL HOME INC. 107 WILKENS AVENUE-BALTIMORE, MD 21229 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Emphysema Due to (or as a consequence of): b. Coronary Heart Failure Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. Signature and title of certifier Stephen Waters MD | | | | 29c. License number 027993 | | 29d. Date signed (Month, Day, Year) 8-15-97 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEPHEN WATERS, MD 1001 PENNA. AVE OCEAN CITY, MD 21842 | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 21 1997 | | | | 32. Registrar's Signature <i>John Davidson-Randall</i> | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at 5058.

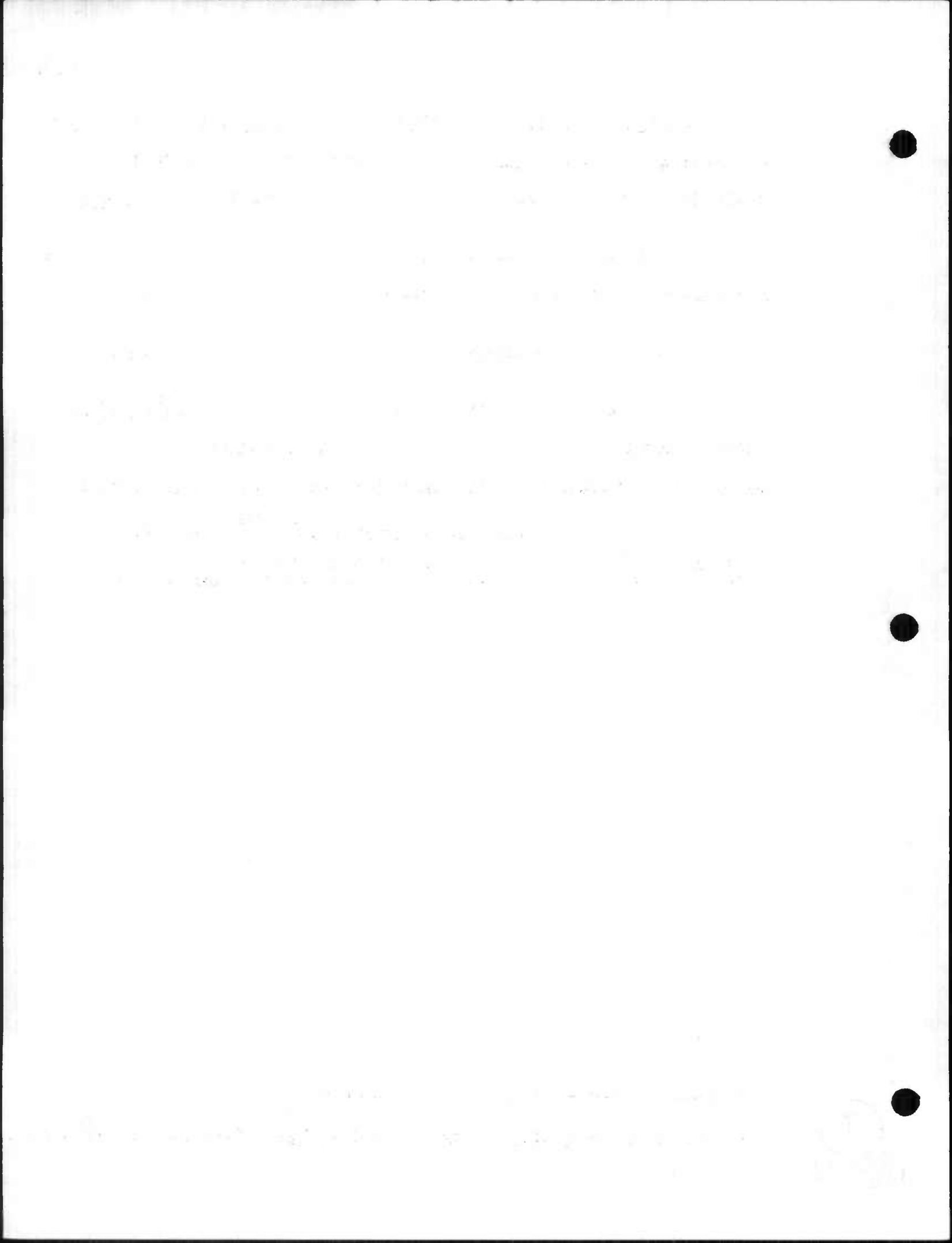
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25185

| | | | | | | | | |
|--|---|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) SHELBY HILLIARD | | | | 2. Date of Death Month Day Year AUGUST 19, 1997 | | 3. Time of Death 0807 | |
| | 4e. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE CITY | | 4c. County of Death | |
| Funeral Director | 5. Social Security Number 212-47-4502 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) Yrs. 1 | | 8. Date of Birth (Month, Day, Year) MAR 12 1996 | |
| | Usual Residence of Decedent | | 10a. State MARYLAND | | 10b. County ANNE ARUNDEL | | 10c. City, Town or Location PASADENA | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 681 213th STREET | | 10f. Zip Code 21122 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) N/A | | 16b. Kind of Business/Industry N/A | | | |
| | 17. Father's Name (First, Middle, Last) MARTIN W. HILLIARD | | | | 18. Mother's Name (First, Middle, Maiden Surname) JAIME MULLIKIN | | | |
| | 19a. Informant's Name/Relationship (Type, Print) MARTIN W. HILLIARD / Father | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 681 213th Street Pasadena Maryland 21122 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) CEDAR HILL CEMETERY | | 20c. Location - City or Town, State Aug. 22, 1997 GLEN BURNIE MD. | | | |
| | 21. Signature of Funeral Service Licensee Hilary L. Stallings Jr. | | 22. Name and Address of Facility STALLINGS FUNERAL HOME P.A. 3111 MOUNTAIN ROAD PASADENA, MARYLAND 21122 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. PULMONARY ARTERY OCCLUSION Due to (or as a consequence of): b. ENTEROCOCCAL SEPSIS AND PNEUMONIA Due to (or as a consequence of): c. BONE MARROW TRANSPLANT Due to (or as a consequence of): d. ACUTE LYMPHOCYTIC LEUKEMIA | | | | | | Approximate Interval Between Onset and Death 1 day 2 weeks 4 months 1 year | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PAN CYTOPENIA | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospitals: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Dr. James S. Nader MD | | 29c. License number RES-000 | | 29d. Date signed (Month, Day, Year) AUGUST 19, 1997 | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) JOANNE E. NATALE, MD THE JOHNS HOPKINS HOSPITAL, BALTIMORE, MD | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) AUG 21 1997 | | 32. Registrar's Signature Julia Davidson-Randall | | | | | |

Baltimore, Maryland 21215-0020

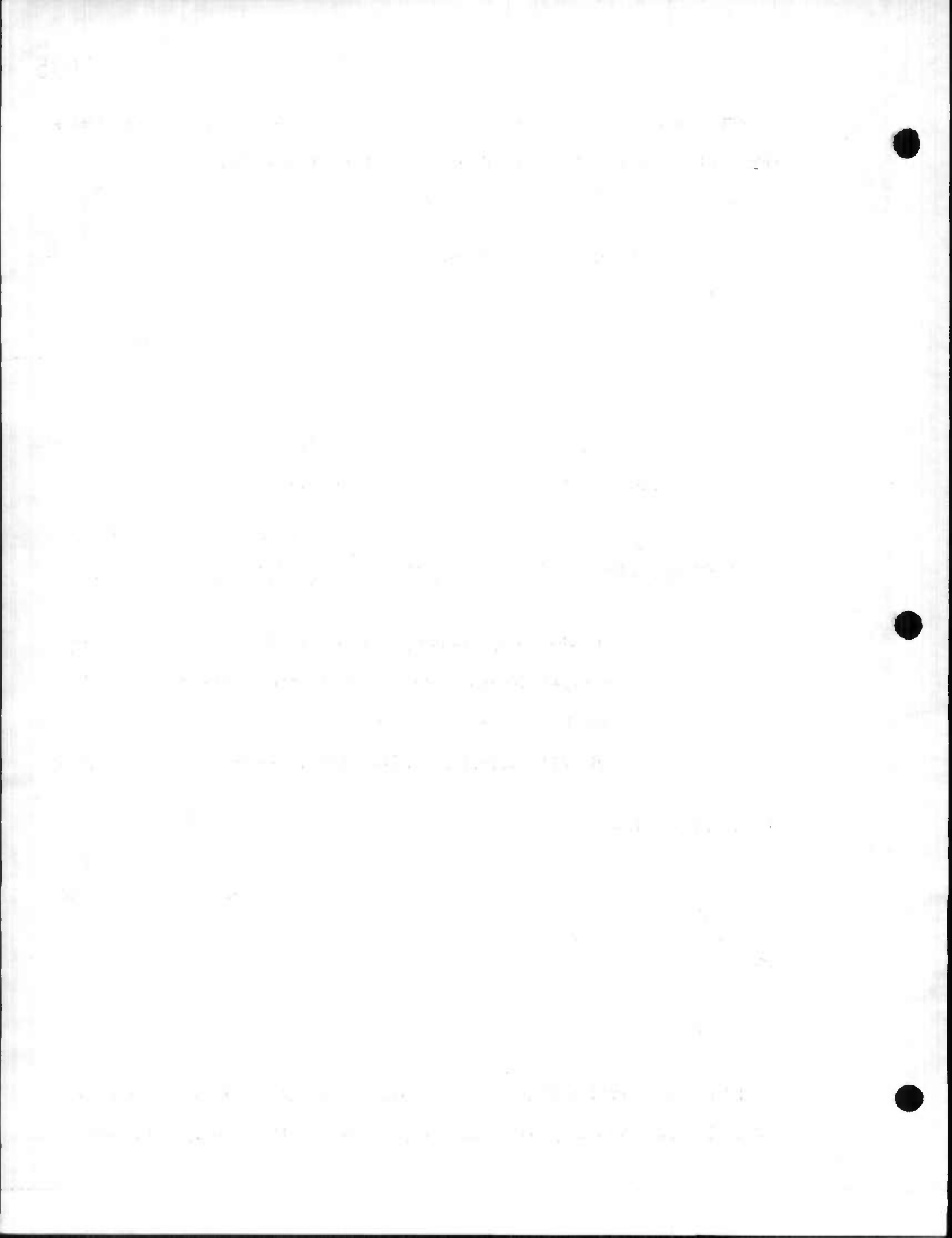
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be attached for use as the burial/transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25186

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|---|---|--|--|--|--|---|---|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Gloria Y. Higgins | | | | 2. Date of Death Month 8 Day 18 Year 1997 | | 3. Time of Death 7:05 P.M. | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not Institution, give street and number) 2928 Silverhill Avenue | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 220-36-7894 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 54 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 5-16-1943 | 9. Birthplace (State or Foreign Country) Md | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Md | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 10e. Street and Number 2928 Silverhill Avenue | | | | 10f. Zip Code 21207 | | 10g. Citizen of What Country? U S A | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th grade College (1-4 or 5+) N/A | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Salad Girl | | 16b. Kind of Business/Industry Deli | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last) William Hall | | | | 18. Mother's Name (First, Middle, Maiden Surname) Evelyn Dyer | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) LaTangela Higgins-Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2928 Silverhill Avenue Baltimore, Md 21207 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Crest Lawn Cemetery | | 20c. Location - City or Town, State Baltimore, Md | | 20d. Date 8-22-97 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee <i>Blynn B. Harris</i> | | | | 22. Name and Address of Facility March F/H West 4300 Wabash Avenue Baltimore, Md 21215 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td rowspan="4"> { a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. </td> <td colspan="6"> e. <i>Lung Cancer</i> Due to (or as a consequence of): </td> </tr> <tr><td colspan="6"></td></tr> <tr><td colspan="6"></td></tr> <tr><td colspan="6"></td></tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | { a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | e. <i>Lung Cancer</i> Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | |
| Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | { a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | e. <i>Lung Cancer</i> Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier <i>Donald Howard</i> | | 29c. License number D 36353 | | 29d. Date signed (Month, Day, Year) 8/20/97 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4120 Patterson Ave Baltimore, MD 21215 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 21 1997 | | 32. Registrar's Signature <i>Juba Davidson-Rendell</i> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25187

Item 26 per Phy Film G750 8-21-97 rja

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Emma Sue Hacker

2. Date of Death

Month Day Year

Aug. 3, 1997

3. Time of Death

3:50 PM

4a. Facility Name (If not institution, give street and number)

1326 Aiken Avenue

4b. City, Town, or Location of Death

Perryville

4c. County of Death

HARFORD

Funeral
Director

5. Social Security Number

363-66-8872

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

58 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
12 10 38

9. Birthplace (State or Foreign Country)

Florida

Usual Residence of Decedent

10a. State

MD

10b. County

HARFORD

10c. City, Town or Location

PERRYVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1326 AIKEN AVE MEXI

10f. Zip Code

21903-2610

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

NANNY

16b. Kind of Business/Industry

Someone Else's Home

17. Father's Name (First, Middle, Last)

William James Quiette

18. Mother's Name (First, Middle, Maiden Surname)

Pearl Fuch

19a. Informant's Name/Relationship (Type, Print)

unknown

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

unknown

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board, 655 W. Baltimore Street
Baltimore, Maryland 21201

23a. Permit. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. METASTATIC BREAST CANCER 3 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 8 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. Signature and title of certifier

John P. Edwards, M.D.

29d. License number

231775

29e. Date signed (Month, Day, Year)

August 11, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

John P. Edwards, M.D.

312 BELAIR ROAD

GASTON, MARYLAND 21047

State
Registrar

31. Date filed (Month, Day, Year)

AUG 21 1997

32. Registrar's Signature

Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25188

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

THELMA A. HAHN

2. Date of Death

Month

Day

Year

AUGUST

19

1997

3. Time of Death

3:35 P.M.

4a. Facility Name (If not Institution, give street and number)

MANOR CARE RUXTON NURSING HOME

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

262-43-2652

6. Sex

1 ☐ M ☒ F

7. Age (in yrs. last birthday)

93

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

11/30/03

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

HARFORD

10c. City, Town or Location

JOPPATOWNE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

409 TANGLEWOOD COURT

10f. Zip Code

21085

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

WHITE

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3 YEARS

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

HARRY J. BONBRAKE

18. Mother's Name (First, Middle, Maiden Surname)

ROSE ROUZER

19a. Informant's Name/Relationship (Type, Print)

JANE MULLIGAN DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

409 TANGLEWOOD COURT JOPPA, MD 21085

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

LOUDON PARK CEMETERY

Date

8/21/97

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD.

TOWSON, MD 21286

23. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure years

Due to (or as a consequence of):

b. Ischemic Heart Disease years

Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Renal Failure
Cerebrovascular Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EVANGELOS C. LIGNOS MD, 7201 YORK RD, TOWSON, MD, 21204

31. Date filed (Month, Day, Year)

AUG 21 1997

32. Registrar's Signature

John Davidson

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25189

| | | | | | | | | |
|---|--|--|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) CARLOS HOCKMAN | | | | 2. Date of Death Month 8 Day 6 Year 97 | | 3. Time of Death 0152 | |
| | 4e. Facility Name (If not institution, give street and number) UNIVERSITY OF MARYLAND MEDICAL SYSTEM | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death BALTIMORE CITY | |
| Funeral Director | 5. Social Security Number 218 22 2420 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 68 Yrs. | | 8. Date of Birth (Month, Day, Year) December 5 1928 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10e. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Parkville | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number 3022 Moreland Ave | | 10f. Zip Code 21234 | |
| | 10g. Citizen of What Country? USA | | | | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Chauffeur | | | | 16b. Kind of Business/Industry Baltimore Gas & Electric | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Albert E. Hockman | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary L. Dennis | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Carla Guercio | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3008 Rosalie Ave. Parkville, Maryland 21234 | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial Park | | 20c. Location - City or Town, State Elkridge, Maryland | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Evans Chapel of Memories 8800 Hartford Rd. Baltimore Md. 21234 | | | |
| To Be Completed by Physician/Medical Examiner | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) INTRACRANIAL HEMORRHAGE Due to (or as a consequence of): FALL Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last PARKINSON'S DISEASE | | | | | | Approximate Interval Between Onset and Death 5 DAYS | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. NON HODGKIN'S LYMPHOMA PARKINSON'S DISEASE | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| To Be Completed by Physician/Medical Examiner | 24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) 7-30-97 | | 28b. Time of Injury Unknown M | |
| | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 28d. Describe how injury occurred FALL DOWNING | | | |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Home | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3022 Moreland Ave Baltimore, Md. 21234 | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier | | | |
| To Be Completed by Physician/Medical Examiner | 29c. License number D19797 | | | | 29d. Date signed (Month, Day, Year) August 6 1997 | | | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) AURELIO RODRIGUEZ SHOCK TRAUMA CENTER BALTIMORE MD | | | | 31. Date filed (Month, Day, Year) AUG 21 1997 | | | |
| To Be Completed by Physician/Medical Examiner | 32. Registrar's Signature | | | | 33. Registrar's Title Julia Davidson-Randall | | | |
| | 34. State Registrar T | | | | 35. State Registrar State Registrar | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25190

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William CHARLES Hohenberger

2. Date of Death

August 16, 1997

3. Time of Death

7:40 A.M.

4a. Facility Name (If not institution, give street and number)

2306 BIRMINGHAM COURT

4b. City, Town, or Location of Death

JARRETTSTOWN

4c. County of Death

HARFORD

Funeral
Director

5. Social Security Number

216-345510

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

60

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JULY 2, 1937

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10e. State

MARYLAND

10b. County

HARFORD

10c. City, Town or Location

JARRETTSTOWN

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

2306 BIRMINGHAM COURT

10f. Zip Code

21084

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12 YRS.

8 YRS.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ADMINISTRATIVE LAW JUDGE

16b. Kind of Business/Industry

STATE OF MARYLAND
O.A.H.

17. Father's Name (First, Middle, Last)

THEODORE HERBERT HOHENBERGER

18. Mother's Name (First, Middle, Maiden Surname)

MARGARET L. SHANAHAN

19a. Informant's Name/Relationship (Type, Print)

MARY ANN HOHENBERGER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2306 BIRMINGHAM CT. JARRETTSTOWN, MARYLAND 21084

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ST. MARY'S CEMETERY

Date

AUG. 19, 1997

20c. Location - City or Town, State

PYLESTOWN, MARYLAND

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

EVANS FUNERAL HOME - BALTIMORE, P.A. 21050
31 NEWPORT DRIVE FOREST HILL, MARYLAND

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Esophageal Cancer
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury first initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

18 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

28. Place of Death (Check only one)

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D30929

29d. Date signed (Month, Day, Year)

AUGUST 19, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PAUL CARMON, MD

TOWSON, MARYLAND
6569 NORTH CHARLES STREET 21064

31. Date filed (Month, Day, Year)

AUG 21 1997

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Item 28abcdef per Phy Film G750 8-21-97 rja

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25191

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

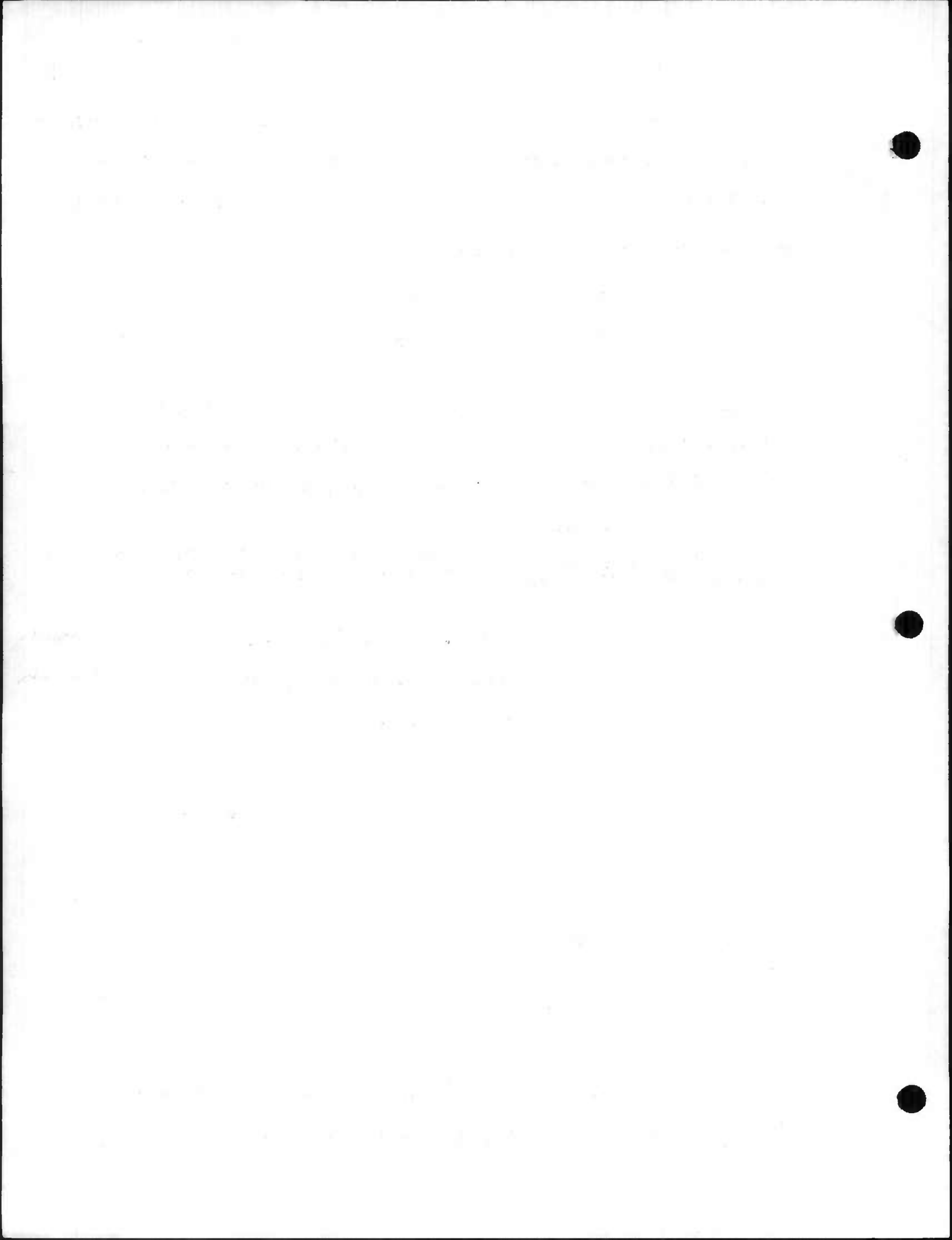
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Charles B. Irwin | | 2. Date of Death Month July Day 26 Year 1997 | | 3. Time of Death 6:20 AM | |
| 4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center | | | 4b. City, Town, or Location of Death Annapolis | | 4c. County of Death Anne Arundel |
| 5. Social Security Number 215-38-5834 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 58 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) March 11, 1939 |
| 9. Birthplace (State or Foreign Country) Maryland | | | | | |
| Usual Residence of Decedent | | | | | |
| 10e. State Maryland | 10b. County Anne Arundel | 10c. City, Town or Location Annapolis | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 10e. Street and Number 1 B. Colonial Avenue | | 10f. Zip Code 21401 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unknown | | 16b. Kind of Business/Industry unknown | |
| 17. Father's Name (First, Middle, Last) William Henry Irwin | | | 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Aileen Davis | | |
| 19a. Informant's Name/Relationship (Type, Print) Helen Marie Godfrey/sister | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Barrin Avenue, Newburg, Pennsylvania 17240 | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) in state | | 20b. Place of Disposition (Name of cemetery, crematory or other place) | | 20c. Location - City or Town, State | |
| 21. Signature of Funeral Service Licensee Ronald S. Wade, Director | | 22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21011 21201 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death) Anoxic brain damage | | | | | 1 month |
| Due to (or as a consequence of): | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Aspiration of foreign object | | | | | 1 month |
| Due to (or as a consequence of): | | | | | |
| Alcoholism | | | | | |
| Due to (or as a consequence of): | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) June 23, 1997 | 28b. Time of Injury unknown | 28c. Injury at Work? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred subject asperated on food |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Hospital ER | | | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) Anne Arundel Med C Annapolis MD | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier R. S. Wade | | 29c. License number 032036 | | 29d. Date signed (Month, Day, Year) 7/26/97 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Gary Sprouse 2108 Piedmont Drive Chicks MD 21619 | | | | | |
| 31. Date filed (Month, Day, Year) AUG 21 1997 | | 32. Registrar's Signature Julia Davidson Randall | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25192

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Deborah Lee Johnson

2. Date of Death

Month Day Year
August 19 1997

3. Time of Death

1:03 PM

4a. Facility Name (If not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

213-90-5460

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

32

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 15, 1964

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1302 Cox Street

10f. Zip Code

21211

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Home Maker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

George Arthur Johnson

18. Mother's Name (First, Middle, Maiden Surname)

Vonnice LaVern Martin

19a. Informant's Name/Relationship (Type, Print)

George A. Johnson (Father)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1302 Cox Street, Baltimore, Maryland 21211

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion UMC Cemetery

Date

8/23/97

20c. Location - City or Town, State

Butler, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

A. Alan Seitz, Jr. Funeral Home
3818 Roland Avenue, Baltimore, Maryland 21211

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Haemorrhagic Shock

Due to (or as a consequence of):

5 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Massive upper gastric intestinal bleeding

Due to (or as a consequence of):

5 days

c. Alcoholic liver cirrhosis

Due to (or as a consequence of):

years

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

AT 2438946-M17

29d. Date signed (Month, Day, Year)

August 19, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PEIDING GAO, 201 E. University Blvd, The Union Memorial Hospital, Baltimore, MD 21218

31. Date filed (Month, Day, Year)

AUG 21 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that this death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be retained for use as the burial-transit form.

Deborah Lee Johnson
Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25193

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Helen Keeton

2. Date of Death

August 19 1997

3. Time of Death

2111

4a. Facility Name (If not institution, give street and number)

ST. AGNES HEALTH CARE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

NA

Funeral
Director

5. Social Security Number

218-22-1954

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 9, 1927

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State
Md

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

916 Sedgley Road

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Clarence White

18. Mother's Name (First, Middle, Maiden Surname)

Helen M. Hill

19a. Informant's Name/Relationship (Type, Print)

Wilburt Keeton Sr. - Hus

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

916 Sedgley Road Balto Md 21228

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Cem

Data

823 97 Balto Md

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

D. Lynn B. Harris

22. Name and Address of Facility

March Funeral Home - West
4300 Wabash Ave. Balto Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CHRONIC NON-HEALING LEG ULCERS

5 YRS

Due to (or as a consequence of):

b. DEBILITATING RHEUMATOID ARTHRITIS

20 YRS

Due to (or as a consequence of):

c. 1

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

FEMUR FRACTURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D50229

29d. Date signed (Month, Day, Year)

8/20/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

JEFFREY LOTLIKAR, M.D. 405 FEDERICK RD #200, BALT MD 21228

31. Date filed (Month, Day, Year)

AUG 21 1997

Registrar's Signature

Julia Davidson-Randall

State
RegistrarBaltimore, Maryland 21215-0020
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The state requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please detach and send to the State Registrar.NAME: Mary H Keeton
Division of Vital Records, P.O. Box 68760,

10-1

1. The first part of the document is a list of names and addresses. The names are: John Doe, Jane Smith, and Bob Johnson. The addresses are: 123 Main St, 456 Elm St, and 789 Oak St.

2. The second part of the document is a list of items and their quantities. The items are: 100 lbs of flour, 50 lbs of sugar, and 25 lbs of butter. The quantities are: 100, 50, and 25.

3. The third part of the document is a list of dates and times. The dates are: 1/1/20, 2/1/20, and 3/1/20. The times are: 10:00 AM, 2:00 PM, and 5:00 PM.

4. The fourth part of the document is a list of locations and distances. The locations are: New York, Los Angeles, and Chicago. The distances are: 100 miles, 200 miles, and 300 miles.

5. The fifth part of the document is a list of names and ages. The names are: John Doe, Jane Smith, and Bob Johnson. The ages are: 30, 40, and 50.

6. The sixth part of the document is a list of names and heights. The names are: John Doe, Jane Smith, and Bob Johnson. The heights are: 5'10", 5'8", and 5'6".

7. The seventh part of the document is a list of names and weights. The names are: John Doe, Jane Smith, and Bob Johnson. The weights are: 180 lbs, 160 lbs, and 140 lbs.

8. The eighth part of the document is a list of names and eye colors. The names are: John Doe, Jane Smith, and Bob Johnson. The eye colors are: Blue, Brown, and Green.

9. The ninth part of the document is a list of names and hair colors. The names are: John Doe, Jane Smith, and Bob Johnson. The hair colors are: Black, Brown, and Blonde.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25194

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Gladys E. Krcek

2. Date of Death

August 20 1997

3. Time of Death

12:40 A.M.

4a. Facility Name (If not institution, give street and number)

3456 - 6th Street

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

212 26 8514

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 5, 1913

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3456 - 6th Street

10f. Zip Code

21225

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

10th

18a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Binder

16b. Kind of Business/Industry

Book Bindery

17. Father's Name (First, Middle, Last)

Nicholas Morris

18. Mother's Name (First, Middle, Maiden Surname)

Mary Kelsall

19a. Informant's Name/Relationship (Type, Print)

Gwendolyn Bruce / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3456 - 6th Street Baltimore, Maryland 21225

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

8/22/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Jerome Januszewski

22. Name and Address of Facility

Gonce Funeral Home P.A.

4001 Ritchie Highway Baltimore, Md. 21225

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Colon Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

{

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

Abdominal Aortic Aneurysm.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Raafat Y. Girgis MD

29c. License number

D31726

29d. Date signed (Month, Day, Year)

8/20/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Raafat Y. Girgis - 724 Maiden Choice LA-Baltimore

31. Date filed (Month, Day, Year)

AUG 21 1997

32. Registrar's Signature

Julia Wideman-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that a death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been reviewed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25195

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Thomas Davidson Lisle

2. Date of Death

Month Day Year
August 14, 1997

3. Time of Death

8:00 P.M.

4e. Facility Name (If not institution, give street and number)

7 Holly Branch Court

4b. City, Town, or Location of Death

Glen Arm

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

270-14-2000

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

4-5-1911

9. Birthplace (State or Foreign Country)

Alabama

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Glen Arm

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7 Holly Branch Court

10f. Zip Code

21057

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Personnel Director

16b. Kind of Business/Industry

Civilian Air Force

17. Father's Name (First, Middle, Last)

Thomas Lisle

18. Mother's Name (First, Middle, Maiden Surname)

Mesia Davidson

19a. Informant's Name/Relationship (Type, Print)

Mrs. Teresa Boria-Lisle/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7 Holly Branch Court Glen Arm, Md. 21057

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Hilltop Service Corp.

Date

8/16/97

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee

Michael P. Ruck

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.

1050 York Road

Towson, Maryland 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

b. Secondary to hypertension

Due to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury et

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

James Ricely, M.D.

29c. License number

H18792

29d. Date signed (Month, Day, Year)

8/15/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

James Ricely, M.D. 6565 N. Charles Street Baltimore, Maryland

31. Date filed (Month, Day, Year)

AUG 21 1997

Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

97 25196

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) DAVID MACON | | | | 2. DATE OF DEATH MONTH 8 DAY 15 YEAR 1997 | | 3. TIME OF DEATH 10:45 A.M. | |
| 4. SOCIAL SECURITY NUMBER 219-32-2373 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 62 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) MAR. 1935 | |
| 8. BIRTHPLACE (State or Foreign Country) SOUTH CAROLINA | | | | 9. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 10. COUNTY OF DEATH N/A | |
| 11. FACILITY NAME (If not institution, give street and number) IRVINGTON KNOLLS NURSING HOME | | | | 12. RESIDENCE OF DECEDENT | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION BALTIMORE CITY | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 2200 HOMEWOOD AVE. APT. 102 | | | | 10f. ZIP CODE 21218 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 6TH GRADE | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LABORER | | 16b. KIND OF BUSINESS/INDUSTRY CANNING FACTORY | | | |
| 17. FATHER'S NAME (First, Middle, Last) ELIJAH MACON | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) IDA LEE TAYLOR | | | |
| 19a. INFORMANT'S NAME (Type/Print) MARIAN WILLIAMS (DAUGHTER) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 EISENDA CT. RANDALLSTOWN, MD. 21133 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CEDAR HILL CEMETERY 8-21-97 | | 20c. LOCATION — City or Town, State GLEN BURNIE, MD. | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | |
| 22. NAME AND ADDRESS OF FACILITY JOSEPH H. BROWN JR. FUNERAL HOME | | 23. ADDRESS OF FACILITY 2140 N. FULTON AVE. BALTO. MD. 21217 | | | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cancer of esophagus with metastasis | | | | | | | |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| b. Esophago pulmonary fistula | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER D39127 | | 29d. DATE SIGNED (Month, Day, Year) 8/16/97 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) A. AHMED M.D. 300 Army Place Baltimore MD 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) AUG 21 1997 | | 32. REGISTRAR'S SIGNATURE | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2000

1. The first part of the report is devoted to a general description of the project and its objectives. It also includes a brief review of the literature on the subject.

2. The second part of the report describes the methodology used in the study. This includes a detailed description of the experimental design, the data collection procedures, and the statistical methods used for data analysis.

3. The third part of the report presents the results of the study. This includes a description of the data, a summary of the findings, and a discussion of the implications of the results.

4. The final part of the report is a conclusion, which summarizes the main findings of the study and provides recommendations for future research.

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10. The second part of the report describes the methodology used in the study. This includes a detailed description of the experimental design, the data collection procedures, and the statistical methods used for data analysis.

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12. The second part of the report describes the methodology used in the study. This includes a detailed description of the experimental design, the data collection procedures, and the statistical methods used for data analysis.

13. The first part of the report is devoted to a general description of the project and its objectives. It also includes a brief review of the literature on the subject.

14. The second part of the report describes the methodology used in the study. This includes a detailed description of the experimental design, the data collection procedures, and the statistical methods used for data analysis.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25197

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|---|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Dwayne Earl Moody | | | 2. Date of Death Month AUGUST Day 17 , Year 1997 | | 3. Time of Death 09:52 AM | | |
| | 4a. Facility Name (If not institution, give street and number) SHOCK TRAUMA UNIT | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | | |
| Funeral Director | 5. Social Security Number 217-66-5284 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 37 Yrs. | | 8. Date of Birth (Month, Day, Year) Jan. 3, 1960 | |
| | Usual Residence of Decedent | | 9. Birthplace (State or Foreign Country) Maryland | | 10. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| To Be Completed by Funeral Director | 10a. State Md. | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number 2311 W. Lanvale Street | | 10f. Zip Code 21216 | | 10g. Citizen of What Country? U.S.A | | | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th grade | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER | | 16b. Kind of Business/Industry Lafayette Market | | | |
| | 17. Father's Name (First, Middle, Last) Frank Townes | | 18. Mother's Name (First, Middle, Maiden Surname) Doris Moody | | 19e. Informant's Name/Relationship (Type, Print) Doris Moody (mother) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2311 W. Lanvale, Baltimore, Maryland 21216 | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Cemetery | | 20c. Location - City or Town, State 8-25-97 Baltimore, Maryland | | | |
| | 21. Signature of Funeral Service Licensee Sharon D. Boykins | | 22. Name and Address of Facility Joseph H. Brown Jr. Funeral Home, PA. 2140 N. Fulton Avenue, Baltimore, Md. 21217 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Stab wounds of torso | | Approximate Interval Between Onset and Death | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Stab wounds of torso | | Due to (or as a consequence of): | | Due to (or as a consequence of): | | Due to (or as a consequence of): | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Stab wounds of torso | | Due to (or as a consequence of): | | Due to (or as a consequence of): | | Due to (or as a consequence of): | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Stab wounds of torso | | Due to (or as a consequence of): | | Due to (or as a consequence of): | | Due to (or as a consequence of): | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | |
| 24e. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) 8-17-97 | | 28b. Time of Injury 0900 M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) JAIL | | 28d. Describe how injury occurred Subject stabbed in jail | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) 300 E. Madison St. | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier James Lake MD | | 29c. License number OCME | | 29d. Date signed (Month, Day, Year) AUGUST 17, 1997 | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) J. LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 21 1997 | | 32. Registrar's Signature Julia Davidson-Rendell | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25198

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Danny E. McCray Sr.

2. Date of Death

Month 8 Day 18 Year 97 7:30AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

3415 Gwynns Falls Pkwy

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

215-52-3452

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

46 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month 12 Day 31 Year 50

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

N/A

10c. City, Town, or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3415 Gwynns Falls Pkwy

10f. Zip Code

21216

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sanitation Worker

16b. Kind of Business/Industry

City

17. Father's Name (First, Middle, Last)

Martin McCray Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Jeannette Smith

19e. Informant's Name/Relationship (Type, Print)

Valarie Winfield

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3415 Gwynns Falls Pkwy Bato, MD 21216

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT. ZION

Date

8/23/97

20c. Location - City or Town, State

Lansdowne, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Gary P. March Funeral Home P.A. 270 Fredhalla Pass, Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Hepato Renal Syndrome

Due to (or as a consequence of):

6 weeks

b.

Chronic Renal Failure

Due to (or as a consequence of):

6 months

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

AIDS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural
2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide5 ☐ Pending Investigation
6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] M Maguire MD

29c. License number

D44303

29d. Date signed (Month, Day, Year)

8/21/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Ann M. Maguire, Sinai Hospital, 2435 W. Belvedere Ave, Baltimore, MD 21215

31. Date filed (Month, Day, Year)

AUG 21 1997

32. Registrar's Signature

[Signature] J. Davidson-Randall

21215

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please detach for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25199

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|---|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Ralph L. Michael | | | | 2. Date of Death Month Day Year August 19 1997 | | 3. Time of Death 6:30 A.M. | |
| | 4e. Facility Name (If not institution, give street and number) 3202 Hilltop Avenue | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 219 28 5084 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 66 Yrs. | | 8. Date of Birth (Month, Day, Year) July 23, 1931 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore | |
| Usual Residence of Decedent | | | | | | | | |
| 10a. State Maryland | | | 10b. County Baltimore | | | 10c. City, Town or Location Baltimore | | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 10e. Street and Number 3202 Hilltop Avenue | | | 10f. Zip Code 21227 | | |
| 10g. Citizen of What Country? U.S. | | | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | | 12. Was Decedent Ever In U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Korean Conflict | | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4or 5+) Operating Engineer | | |
| 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Operating Engineer | | | 16b. Kind of Business/Industry Construction | | | 17. Father's Name (First, Middle, Last) Ralph L. Michael | | |
| 18. Mother's Name (First, Middle, Maiden Surname) Sarah L. Holland | | | 19. Informant's Name/Relationship (Type, Print) Sarah Michael / mother | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3202 Hilltop Avenue Baltimore, Maryland 21227 | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial Pk. | | | 20c. Location - City or Town, State Baltimore, Maryland | | |
| 21. Signature of Funeral Service Licensee <i>Domenica Zmorski</i> | | | 22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 | | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Lung Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | |
| 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | |
| 28a. Date of Injury (Month, Day, Year) | | | 28b. Time of Injury M | | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | 29b. Signature and title of certifier <i>James MD</i> | | | 29c. License number D33448 | | |
| 29d. Date signed (Month, Day, Year) 8/19/97 | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kenneth Williams, M.D. 516 N. Rolling RD #108 Balto. MD 21228 | | | 31. Date filed (Month, Day, Year) AUG 21 1997 | | |
| 32. Registrar's Signature <i>Julia Davidson-Randall</i> | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

1. The first part of the report is a general
description of the project and its objectives.
2. The second part is a detailed description of
the methodology used in the study.
3. The third part is a description of the results
of the study.
4. The fourth part is a discussion of the results
and their implications.
5. The fifth part is a conclusion and a list of
references.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25200

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) DANIEL HERMAN MILLER | | | | 2. Date of Death Month Day Year AUGUST 17 1997 | | 3. Time of Death 9:15 A.M. | |
| | 4a. Facility Name (If not institution, give street and number) ST. JOSEPH MEDICAL CENTER | | | | 4b. City, Town, or Location of Death TOWSON | | 4c. County of Death BALTIMORE | |
| Funeral Director | 5. Social Security Number 217-14-5352 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 78 Yrs. | | 8. Date of Birth (Month, Day, Year) 7/14/19 | |
| | 9. Birthplace (State or Foreign Country) MARYLAND | | 10a. State MD | | 10b. County BALTIMORE | | 10c. City, Town or Location RIDGELEIGH | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 1863 YAKONA ROAD | | 10f. Zip Code 21234 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th GRADE College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MACHINE OPERATOR | | 16b. Kind of Business/Industry BLACK & DECKER | | | |
| | 17. Father's Name (First, Middle, Last) RUDOLPH MUELLER | | | | 18. Mother's Name (First, Middle, Maiden Surname) LOUISE STRAUBE | | | |
| | 19a. Informant's Name/Relationship (Type, Print) ELSIE E. MILLER WIFE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1863 YAKONA ROAD BALTIMORE, MD 21234 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) PARKWOOD CEMETERY | | 20c. Date 8/21/97 | | 20d. Location - City or Town, State BALTIMORE, MD | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 | | | |
| | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="width: 15%;"> <p>Approximate Interval Between Onset and Death</p> </div> </div> <p>a. Ruptured Abdominal Aortic Aneurysm immediate</p> <p>b. Chronic Abdominal Aortic Aneurysm 10 yrs.</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier | | 29c. License number D32783 | | 29d. Date signed (Month, Day, Year) 8/18/97 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Adams MD 7401 Osler Drive S. 406 Towson Md 21204 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 21 1997 | | 32. Registrar's Signature | | | | | | |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: This law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate is signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25201

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

RICHARD EDWARD MANSOLILLO

2. Date of Death

Month Day Year
AUGUST 17, 1997

3. Time of Death

5:00 A.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

CHARLESTOWN CARE CENTER

4b. City, Town, or Location of Death

CATONSVILLE

4c. County of Death

BALTIMORE

5. Social Security Number

072-10-8553

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JUN. 9, 1914

9. Birthplace (State or Foreign Country)

N.Y.

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

CATONSVILLE

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

719 MAIDEN CHOICE LANE HR#533

10f. Zip Code

21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

BANKER

16b. Kind of Business/Industry

FEDERAL RESERVE

17. Father's Name (First, Middle, Last)

JOSEPH MANSOLILLO

18. Mother's Name (First, Middle, Maiden Surname)

LOUISE APICELLA

19a. Informant's Name/Relationship (Type, Print)

ELEANOR MANSOLILLO (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

719 MAIDEN CHOICE LANE HR#533 CATONSVILLE MD 21228

20a. Method of Disposition

☐ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☒ Other (Specify) ENTOMBMENT

20b. Place of Disposition (Name of cemetery, crematory or other place)

GATE OF HEAVEN CEMETERY

Date

8/20/97

20c. Location - City or Town, State

SILVER SPRING MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

WITZKE FUNERAL HOME, INC. OF COLUMBIA
5555TWIN KNOLLS ROAD COLUMBIA MD 21045

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of):

Pneumonia

Approximate Interval Between Onset and Death

days

b.

Due to (or as a consequence of):

Dementia

years

c.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

26. Place of Death (Check only one)

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

047447

29d. Date signed (Month, Day, Year)

August 18, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Andrew Lazaris, 711 Maiden Choice Lane, Catonsville.

31. Date filed (Month, Day, Year)

AUG 21 1997

32. Registrar's Signature

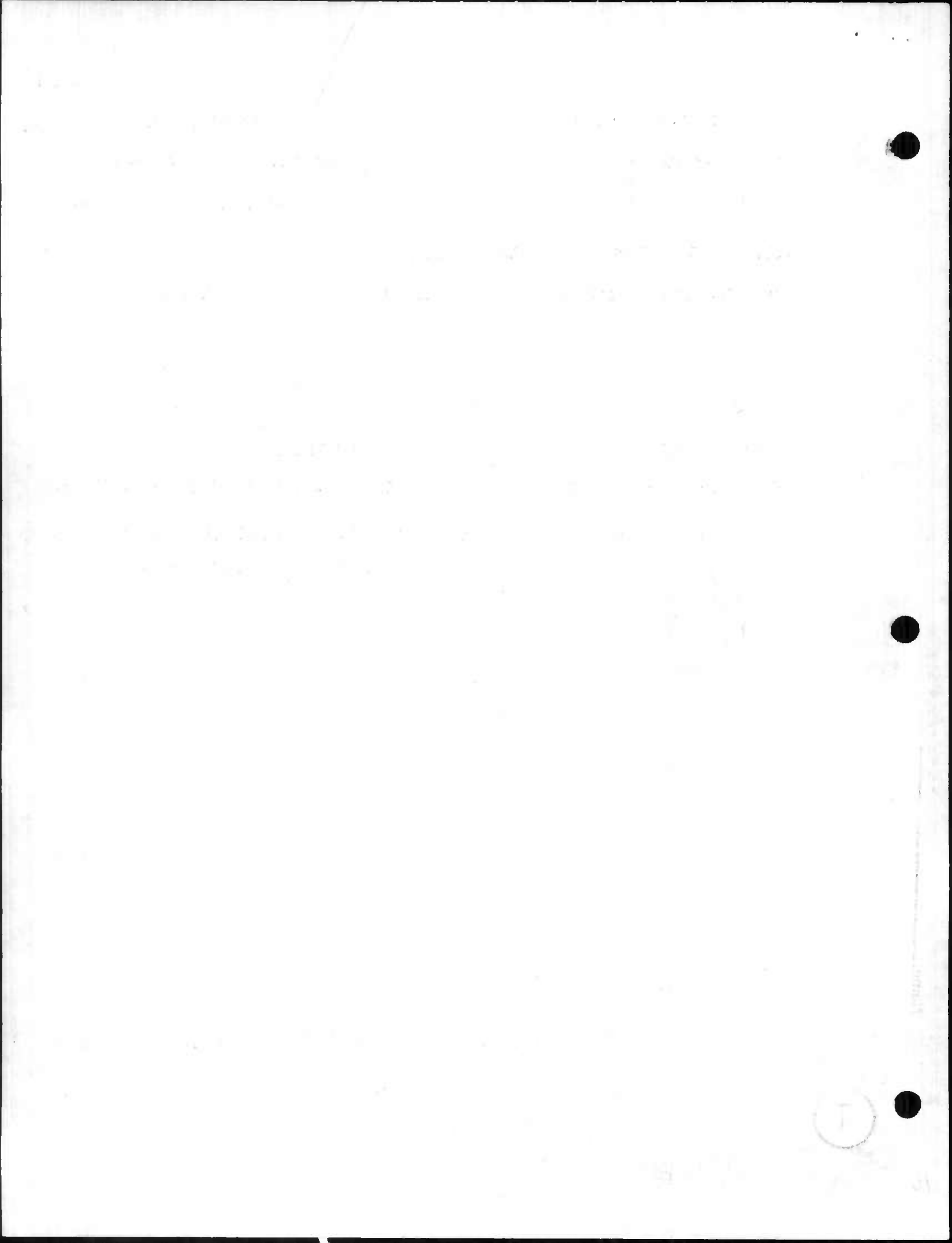
Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

T

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25202

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LESLIE TAYLOR MORTIMER

2. Date of Death

Month August 18 1997 Year 10:50 AM

3. Time of Death

Funeral
Director

4e. Facility Name (If not Institution, give street and number)

ST. AGNES HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

N/A

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months Days

5

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

AUG. 13, 1997

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

CATONSVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

638 INGLESIDE AVENUE

10f. Zip Code

21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

N/A

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

DAVID MORTIMER

18. Mother's Name (First, Middle, Maiden Surname)

SANDRA JOHNSON

19e. Informant's Name/Relationship (Type, Print)

SANDRA MORTIMER (MOTHER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

638 INGLESIDE AVENUE CATONSVILLE MD 21228

20e. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

20c. Location - City or Town, State

CARROLL CREMATION SERVICE 8/22/97 HAMPSTEAD MARYLAND

21. Signature of Funeral Service Licensee

Sandra L. Lemmer

22. Name and Address of Facility

WITZKE FUNERAL HOME OF CATONSVILLE, INC.

1630 EDMONDSON AVENUE CATONSVILLE MARYLAND 21228

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

e. PROBABLE SEPSIS

Due to (or as a consequence of):

Days

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Early Necrotizing Enterocolitis, Severe Metabolic Acidosis,
Bilateral Adrenal Hemorrhage, Thrombocytopenia with Coagulopathy
with possible hemorrhagic hepatic necrosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?X ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?X ☒ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29e. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David P. Frishberg MD

29c. License number

D47380

29d. Date signed (Month, Day, Year)

August 19, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. David P. Frishberg St. Agnes HealthCare 900 Caton Avenue Baltimore, MD 21229

31. Date filed (Month, Day, Year)

AUG 21 1997

32. Registrar's Signature

Julia Davidson-Randall

State
RegistrarBaltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

MORTIMER, LESLIE T.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25203

Certificate of Death

Reg. No.

| | | | | | |
|--|---|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Pauline S Murray | | 2. Date of Death Month Day Year August 18 1997 | | 3. Time of Death 7:53 PM |
| | 4a. Facility Name (If not institution, give street and number) Laurel Regional Hospital | | 4b. City, Town, or Location of Death Laurel | | 4c. County of Death Prince George |
| Funeral Director | 5. Social Security Number 212-26-5162 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 68 Yrs. | 8. Date of Birth (Month, Day, Year) 12. 29. 28 | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | 10b. County Howard | 10c. City, Town or Location Laurel | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10e. Street and Number 10169 Highridge Road | | 10f. Zip Code 20723 | | 10g. Citizen of What Country? USA |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 0 | | |
| | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | | |
| | 17. Father's Name (First, Middle, Last) Harry S. Sherman | | 18. Mother's Name (First, Middle, Maiden Surname) Marie C. Stansbury | | |
| | 19a. Informant's Name/Relationship (Type, Print) Karen Everly/Daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8307 Strahle Place, Philadelphia, PA 19111 | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Washington Cr. | | 20c. Location - City or Town, State Laurel, Maryland |
| | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | 22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707 | | |
| | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | |
| Physician /Medical Examiner | Immediate Cause (Final disease or condition resulting in death) a. Bilateral Pulmonary emboli Due to (or as a consequence of): b. Early hemorrhagic infarction lower lobes Due to (or as a consequence of): c. Pulmonary congestion and edema Due to (or as a consequence of): d. | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1. Stroke recent fracture and dislocation left shoulder 2. History of Diabetes and hypertension | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M |
| | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | 29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | |
| 29b. Signature and title of certifier William A Warren M.D. | | 29c. License number D13916 | | 29d. Date signed (Month, Day, Year) August 19, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) William A. Warren, M.D. 321 Prince George St., Laurel, Maryland 20707 | | | | | |
| 31. Date filed (Month, Day, Year) AUG 21 1997 | | 32. Registrar's Signature <i>[Signature]</i> | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

RA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25204

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GEORGE D. MIMAROS

2. Date of Death

Month Day Year
August 19, 1997

3. Time of Death

12:04 P.M.

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

219-76-3373

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 25, 1932

9. Birthplace (State or Foreign Country)

Greece

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

634 S. Ponca Street

10f. Zip Code

21224

10g. Citizen of What Country?

Greece

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
6th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Machinist

16b. Kind of Business/Industry

Medical

17. Father's Name (First, Middle, Last)

~~Dimitrios G. Mimaros~~

DIMITRIOS K. MIMAROS

18. Mother's Name (First, Middle, Maiden Surname)

~~Eleni Kabanopoulos~~ DESPINA KAMPANOPOULOS

19a. Informant's Name/Relationship (Type, Print)

Mrs. Paraskevi Mimaros, wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

634 S. Ponca Street, Baltimore, Md. 21224

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oak Lawn Cemetery

Date

8-22-97

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Matthews Funeral Home

3021 Eastern Ave., Baltimore, Md. 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Lung Cancer.

Due to (or as a consequence of):

b.

Hemoptysis.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

3 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation
☐ Accident ☐ Suicide
☐ Homicide ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Medical Examiner

29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. Signature and title of certifier

29d. License number

D 28949

29e. Date signed (Month, Day, Year)

8/20/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

P.A. BALTAZIS, MD, 8113 HARFORD RD., BALTIMORE, MD 21234

31. Date filed (Month, Day, Year)

AUG 21 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25205

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Rita M. Morris

2. Date of Death

Month
08Day
17Year
97

3. Time of Death

Unknown
(Early AM)

4a. Facility Name (If not institution, give street and number)

2530 McELDERRY STREET

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

216-30-0573

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

62 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

11/16/34

9. Birthplace (State or Foreign Country)

NEW JERSEY

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2530 McELDERRY STREET

10f. Zip Code

21205

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

9th grade

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOUSEKEEPER

16b. Kind of Business/Industry

HOWARD JOHNSON'S

17. Father's Name (First, Middle, Last)

ARTHUR SHANKS

18. Mother's Name (First, Middle, Maiden Surname)

BERNICE PEACE

19a. Informant's Name/Relationship (Type, Print)

Elizabeth Francis-Rice/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2530 McElderry St, Baltimore, Maryland 21205

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT. ZION CEMETERY

Date

8-23

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

Hani P. Clary

22. Name and Address of Facility

WILLIAM C. BROWN COMMUNITY F/H
1206 W. NORTH AVENUE

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Coronary Vascular and cerebrovascular disease

12/96

Due to (or as a consequence of):

b. Hypertension

Years

Due to (or as a consequence of):

c. Smoking

Years

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Colon Cancer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Jessica L. Dodge M.D.

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

8/17/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Jessica Dodge Dept. of Pathology The Johns Hopkins Hospital 600 N. Wolfe St. Baltimore, MD 21287

31. Date filed (Month, Day, Year)

AUG 21 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25206

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Rita Marie Noonan

2. Date of Death

Month

Day

Year

3. Time of Death

2143

4a. Facility Name (If not institution, give street and number)

Carroll Co. General Hospital

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

Funeral
Director

5. Social Security Number

140-03-4720

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

08-01-15

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll County

10c. City, Town or Location

Westminster

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

460 Avenel Circle

10f. Zip Code

21158

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 Years

College (1-4 or 5+)

4 Years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Owner/Operator

16b. Kind of Business/Industry

Employment Agency

17. Father's Name (First, Middle, Last)

Raffaele Esposito

18. Mother's Name (First, Middle, Maiden Surname)

Rosa DeAlessandro

19e. Informant's Name/Relationship (Type, Print)

Mr. Edward Noonan (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

801 Ryder Court Westminster, MD 21158

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Madonna Cemetery

Date

8/22/1997 Fort Lee, New Jersey

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Loring Byers Funeral Directors, Inc.

8728 Liberty Road Randallstown, MD 21133

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Auto myocardial infarction

Due to (or as a consequence of):

b. Hypertensive Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 days

several yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D20806

29d. Date signed (Month, Day, Year)

8/17/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ATRIK TURNER MD

1425 LIBERTY RD ELDORSBURG, MD 21784

31. Date filed (Month, Day, Year)

AUG 21 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25207

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|--|--|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MARGARET OLIVER | | | | 2. Date of Death Month August Day 17 Year 1997 | | 3. Time of Death 2:45/A | |
| | 4a. Facility Name (If not institution, give street and number) Stella Maris Hospice | | | | 4b. City, Town, or Location of Death TIMONIUM | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 218-26-3796 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 65 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Dec 20, 1931 | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Parkville | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10e. Street and Number 9904 Brittain Lane | | | | 10f. Zip Code 21234 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9Yrs College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker | | 16b. Kind of Business/Industry Home | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Louis Langhirt | | | | 18. Mother's Name (First, Middle, Maiden Surname) Marie J. Mueller | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Valerie Streib | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9904 Brittain Lane Baltimore, Md 21234 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Heart of Jesus | | Date Aug 21 1997 | 20c. Location - City or Town, State Baltimore Maryland | | |
| | 21. Signature of Funeral Service Licensee Krista S. Wells | | 22. Name and Address of Facility Evans Chapel of Memories 8800 Harford Rd. Baltimore, Md 21234 | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ca. of Vagina Due to (or as a consequence of): b. Sm. Bowel Obstruction Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | Approximate interval between Onset and Death |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) HOSPICE | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier [Signature] | | 29c. License number 175504 | | 29d. Date signed (Month, Day, Year) 8 18 97 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. EDDIE NAKHODA 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 21 1997 | | 32. Registrar's Signature [Signature] | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25208

Item: 18 per FH G-750 8/21/97 dh

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DANISE PHILLIPS

2. Date of Death

Month Day Year
AUGUST 17 1997

3. Time of Death

6:00 AM

4a. Facility Name (If not institution, give street and number)

SINAI HOSPITAL OF BALTIMORE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE CITY

Funeral
Director

5. Social Security Number

218640594

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

43 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
OCTOBER 8, 1953

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State
MARYLAND10b. County
BALTIMORE CITY10c. City, Town or Location
BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3509 POWHATAN AVE

10f. Zip Code

21216

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2 YRS.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

COMPUTER OPERATOR

16b. Kind of Business/Industry

COMCAST CABLEVISION

17. Father's Name (First, Middle, Last)

WALTER L. PRICE

18. Mother's Name (First, Middle, Maiden Surname)

MARY C. WILLIAMS PRICE

19a. Informant's Name/Relationship (Type, Print)

MARY PRICE (MOTHER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3509 POWHATAN AVE. BALTIMORE, MD. 21216

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

METRO CREMATORY

Date

8-18-97 BALTIMORE, MARYLAND

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

D.B.

22. Name and Address of Facility

JOSEPH H. BROWN JR. FUNERAL HOME, P.A.
2140 N. FULTON AVE. BALTIMORE, MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

STAGE IVB CERVICAL CARCINOMA

Approximate interval between Onset and Death

2 MONTHS

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

NO INJURY

28b. Time of Injury

N/A

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

N/A

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

N/A

28f. Location (Street and Number or Rural Route Number, City or Town, State)

N/A

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

D. BOWERS

29c. License number

AS 240232108

29d. Date signed (Month, Day, Year)

8/17/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DEBORAH BOWERS M.D. SINAI HOSPITAL OF BALTIMORE, BALTIMORE, MD 21215

31. Date filed (Month, Day, Year)

AUG 21 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

4

1. The first part of the paper is devoted to a general discussion of the problem. It is shown that the problem is well-posed and that the solution exists and is unique.

2. In the second part, the problem is solved for the case of a constant coefficient. The solution is obtained by the method of separation of variables.

3. In the third part, the problem is solved for the case of a variable coefficient. The solution is obtained by the method of variation of parameters.

4. In the fourth part, the problem is solved for the case of a non-linear coefficient. The solution is obtained by the method of perturbation theory.

5. In the fifth part, the problem is solved for the case of a non-local coefficient. The solution is obtained by the method of integral equations.

6. In the sixth part, the problem is solved for the case of a non-homogeneous boundary condition. The solution is obtained by the method of Green's functions.

7. In the seventh part, the problem is solved for the case of a non-linear boundary condition. The solution is obtained by the method of perturbation theory.

8. In the eighth part, the problem is solved for the case of a non-local boundary condition. The solution is obtained by the method of integral equations.

9. In the ninth part, the problem is solved for the case of a non-homogeneous initial condition. The solution is obtained by the method of Green's functions.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 25209

Reg. No.

| | | | | | | | | |
|---|--|---|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Charles REID | | | | 2. Date of Death Month Day Year August 19, 1997 | | 3. Time of Death 6:15 am | |
| | 4e. Facility Name (If not institution, give street and number) Franklin Square Hospital Center | | | | 4b. City, Town, or Location of Death Rosedale | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 212-20-2570 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 73 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) JULY 25, 1924 MARYLAND | | 9. Birthplace (State or Foreign Country) |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MARYLAND | | 10b. County BALTIMORE | | 10c. City, Town or Location ROSEDALE | | 10e. Street and Number 1800 HANFORD ROAD | | |
| 10f. Zip Code 21237 | | 10g. Citizen of What Country? U.S.A. | | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: W.W.II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YRS. College (1-4 or 5+) 8 YRS. | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SELF EMP. | | 16b. Kind of Business/Industry ATTORNEY + ACCOUNTANT | | |
| 17. Father's Name (First, Middle, Last) William J. Reid | | | | 18. Mother's Name (First, Middle, Maiden Surname) ESTELLE DUFF | | | | |
| 19a. Informant's Name/Relationship (Type, Print) GERALDINE M. REID | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1800 HANFORD ROAD BALTIMORE, MARYLAND 21237 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) PARKWOOD CEMETERY | | Date AUG. 22 1997 | | 20c. Location - City or Town, State PARKVILLE, MARYLAND | | |
| 21. Signature of Funeral Service Licensee [Signature] | | | | 22. Name and Address of Facility EVANS CHAPEL OF MEMORIES 21234 8800 HANFORD ROAD PARKVILLE, MARYLAND | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | e. Myocardial Infarction Due to (or as a consequence of): | | | | | | Approximate Interval Between Onset and Death 6 Hours |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | b. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): | | | | | | |
| | | c. Due to (or as a consequence of): | | | | | | |
| | | d. Due to (or as a consequence of): | | | | | | |
| | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Selwyn E. Mahon M.D. | | 29c. License number D47765 | | 29d. Date signed (Month, Day, Year) August 19, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Selwyn Mahon M.D. 6603 Evanston Street Forrestville, Maryland 20747 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 21 1997 | | 32. Registrar's Signature [Signature] | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25210

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GEORGE E. RASSA

2. Date of Death

Month

Day

Year

Aug

20

1997

3. Time of Death

7:45 AM

4a. Facility Name (If not institution, give street and number)

1002 KATY LANE

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

218-14-8724

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

JAN 27, 1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

TOWSON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1002 KATY LANE

10f. Zip Code

21286

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Military

16b. Kind of Business/Industry

Army Air

17. Father's Name (First, Middle, Last)

JOHN E. RASSA

18. Mother's Name (First, Middle, Maiden Surname)

CATHERINE A. BELT

19a. Informant's Name/Relationship (Type, Print)

LEROY J. RASSA SR

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2315 Warfield Dr. Forest Hill, Md. 21050

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Cemetery

Date

Aug 22 1997

20c. Location - City or Town, State

Balto. Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

EVANS Chapel of Memories 8800 Harford Rd

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive heart failure
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ASCVD
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

028662

29d. Date signed (Month, Day, Year)

8/21/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. BRIAN KAHN 7505 Osler Dr. Suite 410 Towson, Maryland

31. Date filed (Month, Day, Year)

AUG 21 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Item: 28f, per MEO G-750 8/21/97 reb

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN REEL

2. Date of Death

08 13 97

3. Time of Death

2 AM

4a. Facility Name (If not institution, give street and number)

SHOCK TRAUMA UNIV MD BALTO MORE

4b. City, Town, or Location of Death

4c. County of Death

BALTO C 17

Funeral
Director

5. Social Security Number

167-22-1353

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept. 22, 1930

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14319 Bonnett Lane

10f. Zip Code

20707

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

1970

1973

46-73

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

XX

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Driver Musician

18b. Kind of Business/Industry

Military

Courier Service

17. Father's Name (First, Middle, Last)

Emerson Reel

18. Mother's Name (First, Middle, Maiden Surname)

Meda Marks

19a. Informant's Name/Relationship (Type, Print)

Anneliese Reel/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14319 Bonnett Lane, Laurel, Maryland 20707

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Data

Baltimore Washington Cr. 8/17

20c. Location - City or Town, State

Laurel, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fleck Funeral Home, Inc.

7601 Sandy Spring Road, Laurel, Maryland 20707

23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of death.

Shock, or heart failure. List only one cause of death.

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE

Due to (or as a consequence of):

b. GASTROINTESTINAL BLEEDING

Due to (or as a consequence of):

c. SPINAL CORD INJURY

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

08 01 97

28b. Time of Injury

12 AM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

FELL AT HOME

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

HOME

28f. Location (Street and Number or Rural Route Number, City or Town, State)

14319 BONNET LANE

LAUREL, MARYLAND

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

George Testerman

29c. License number

051501

29d. Date signed (Month, Day, Year)

08.13.97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GEORGE TESTERMAN 22 SOUTH GREEN ST BALTIMORE

State
Registrar

31. Date filed (Month, Day, Year)

AUG 21 1997

32. Registrar's Signature

Julia Anderson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the extent that the attending physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

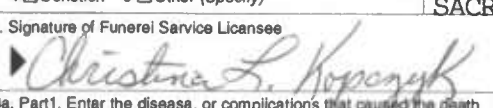


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25212

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|---|--|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Margaret Thelma Sommerman | | | | 2. Date of Death Month Day Year August 16 1997 | | 3. Time of Death 11:40 am | |
| | 4a. Facility Name (If not institution, give street and number) Bayview Medical Center | | | | 4b. City, Town, or Location of Death Baltimore City | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 218-44-9670 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 87 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 6/24/10 | 9. Birthplace (State or Foreign Country) MARYLAND |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE CITY | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 6401 LOCH RAVEN BLVD. | | | | 10f. Zip Code 21239 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4th GRADE College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER | | | 16b. Kind of Business/Industry OWN HOME | |
| 17. Father's Name (First, Middle, Last) WILLIAM JOHN BATES | | | | 18. Mother's Name (First, Middle, Maiden Surname) CAROLINE FLEISHMAN | | | | |
| 19a. Informant's Name/Relationship (Type, Print) CAROLYN M. JACOBSON COUSIN | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7918 STRATMAN ROAD BALTIMORE, MD 21222 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) SACRED HEART OF JESUS CEM. | | 20c. Location - City or Town, State 8/19 DUNDALK, MD | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death) Coronary Artery Disease | | | | | | | | 5 years |
| Due to (or as a consequence of): Carcinoma of Bladder | | | | | | | | 3 years |
| Due to (or as a consequence of): | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier  M.D. | | 29c. License number D14160 | | 29d. Date signed (Month, Day, Year) 08/18/97 |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Harjit Singh, M.D. 5410 -A Ritchie Highway Baltimore, Md. 21225 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 21 1997 | | | | 32. Registrar's Signature  | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25213

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|--|--|--|--------------------------------|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) EDGAR W. SANTMYER | | | | 2. Date of Death Month Day Year August 17, 1997 | | 3. Time of Death 9:44PM | |
| | 4e. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE CITY | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 216-03-8876 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 78 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) NOV 6, 1918 | 9. Birthplace (State or Foreign Country) BALTO., MD |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10e. State MD | | 10b. County BALTIMORE | | 10c. City, Town or Location CATONSVILLE | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number 507 BLOOMINGDALE AVENUE | | | | 10f. Zip Code 21228 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW 11 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH GRADE College (1-4or 5+) | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) UNION DELEGATE | | 16b. Kind of Business/Industry TEAMSTERS UNION | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) JAMES WARREN SANTMYER | | | | 18. Mother's Name (First, Middle, Maiden Surname) MYRTLE WOLF | | | |
| | 19e. Informant's Name/Relationship (Type, Print) MAY M. DEVAN (DAUGHTER) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1950 GARDINA STREET - ELDERSBURG, MD 21784 | | | |
| | 20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) LOUDON PARK CEMETERY | | Date 8/20/97 | | 20c. Location - City or Town, State BALTIMORE | |
| | 21. Signature of Funeral Service Licensee <i>Jackie D. Shannon</i> | | | | 22. Name and Address of Facility HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229 | | | |
| Physician /Medical Examiner | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Myocardial Infarction Due to (or as a consequence of): b. Coronary artery disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | Approximate Interval Between Onset and Death 1.5 hours 20 years | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. hypertension hypercholesterolemia | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| State Registrar | 29b. Signature and title of certifier Sonja K. Fredrickson, MD | | | | 29c. License number RES-000 | | 29d. Date signed (Month, Day, Year) August 17, 1997 | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 600 N. Wolfe Street Baltimore, MD 21287 SONJA K. FREDRICKSON | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 21 1997 Registrar's Signature <i>John Davidson-Randall</i> | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25214

Item 24a per PHY Film G750 8-21-97 rja

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|--|---|--|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Frances A. Schaub | | | | 2. Date of Death Month July Day 31 Year 1997 | | 3. Time of Death 5:59 AM | |
| | 4a. Facility Name (If not institution, give street and number) 1 Maidstone Court Apt. 1K | | | | 4b. City, Town, or Location of Death Rosedale | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 216-09-9912 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 87 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) April 24, 1910 Maryland | |
| | 9. Birthplace (State or Foreign Country) Maryland | | | | | | | |
| Usual Residence of Decedent | | | | | | | | |
| 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Rosedale | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 1 Maidstone Court Apt. 1K | | | | 10f. Zip Code 21237 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | 16b. Kind of Business/Industry Own Home | |
| 17. Father's Name (First, Middle, Last) Alvin W. Weber | | | | 18. Mother's Name (First, Middle, Maiden Surname) Charlotte Cadell | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Frank Weber / Brother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 366 Riverside Drive Pasadena, MD 21122 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp. | | Date 8/2/97 | | 20c. Location - City or Town, State Towson, Maryland | | |
| 21. Signature of Funeral Service Licensee Timothy S. Harman | | | | 22. Name and Address of Facility Leonard J. Ruck, Inc. Funeral Home 5305 Harford Road Baltimore, MD 21214 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | |
| Immediate Cause (Final disease or condition resulting in death) a. metastatic breast carcinoma Due to (or as a consequence of): b. coronary Artery Disease Due to (or as a consequence of): c. Diabetes Due to (or as a consequence of): d. | | | | | | | | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number D 31464 | | 29d. Date signed (Month, Day, Year) 8/1/97 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHOAB A. HASHTMI M.D. 821 N. EUTAW ST Suite 308 Baltimore MD | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 21 1997 | | | | 32. Registrar's Signature | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25215

Item 1,23a Per PHY Film G750 8-20-97 rja

Certificate of Death

Reg. No.

| | | | | | |
|--|--|--|---|---|--|
| Physician /Medical Examiner | 1. Decedant's Name (First, Middle, Last) Donald BRIAN Stahlman | | 2. Date of Death Month Day Year AUGUST 11, 1997 | | 3. Time of Death 6:10p |
| | 4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | 4b. City, Town, or Location of Death BALTIMORE CITY | | 4c. County of Death |
| Funeral Director | 5. Social Security Number 205-34-6937 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 53 Yrs. | 8. Date of Birth Month Day Year OCTOBER 16, 1943 | 9. Birthplace (State or Foreign Country) PENNSYLVANIA |
| | Usual Residence of Decedant | | | | |
| To Be Completed by Funeral Director | 10a. State VIRGINIA | 10b. County FAIRFAX | 10c. City, Town or Location ALEXANDRIA | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10e. Street and Number 5902 MT. EAGLE DRIVE, #815 | | 10f. Zip Code 22303 | | 10g. Citizen of What Country? U.S.A. |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedant Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedant of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | |
| | 15. Decedant's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4 or 5+) 5+ | | 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MANAGEMENT CONSULTANT | | 16b. Kind of Business/Industry PRODUCTIVITY IMPROVEMENT |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) STANLEY STAHLMAN | | 18. Mother's Name (First, Middle, Maiden Surname) ELIZABETH BLAKESLEY | | |
| | 19a. Informant's Name/Relationship (Type, Print) CAROLE KORDICH | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5902 MT. EAGLE DRIVE, #815, ALEXANDRIA, VA. 22303 | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MT. COMFORT CREMATORY | | 20c. Location - City or Town, State ALEXANDRIA, VIRGINIA |
| | 21. Signature of Funeral Service Licensee Lisa D. Williams | | 22. Name and Address of Facility DEMAINE FUNERAL HOMES, INC. ALEXANDRIA, VIRGINIA 22314 | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Respiratory Failure DUE TO LUNG TRANSPLANT Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death 2 months | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | | |
| 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier Eric Peck Resident Physician | | | | | |
| 29c. License number RES-000 | | | | | |
| 29d. Date signed (Month, Day, Year) August 11, 1997 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eric Peck The Johns Hopkins Hospital Baltimore, MD | | | | | |
| 31. Date filed (Month, Day, Year) AUG 21 1997 | | | | | |
| 32. Registrar's Signature Julia Davidson-Pendell | | | | | |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25216

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|---|---|--|--|--|---|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MARY C SHAUGHNESSY | | | | 2. Date of Death Month AUGUST Day 16 Year 1997 | | 3. Time of Death 09:50 AM | |
| | 4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center | | | | 4b. City, Town, or Location of Death Towson | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 381-44-6379 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 52 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) August 31, 1944 | | 9. Birthplace (State or Foreign Country) Michigan |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | 10b. County Baltimore | 10c. City, Town or Location Carney | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number 2 D Rosecrans Ct. | | | 10f. Zip Code 21234 | | 10g. Citizen of What Country? USA | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs | | College (1-4 or 5+) 2 yrs | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sr. Product Support Administrator | | 16b. Kind of Business/Industry Allied Signal | |
| | 17. Father's Name (First, Middle, Last) Benedick V. Kimmel | | | | 18. Mother's Name (First, Middle, Maiden Surname) Marie D. Arseneault | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Marie D. Harris mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8452 Dale Deereborn Heights Michigan 48127 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery | | 20c. Location - City or Town, State Aug. 19 1997 Parkville, Maryland | | Approximate Interval Between Onset and Death YEARS | |
| | 21. Signature of Funeral Service Licensee Krista S. Wells | | | | 22. Name and Address of Facility Evans Chapel of Memories 8800 Harford Rd Baltimore, Md 21234 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| | <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>ADENOCARCINOMA OF COLON WITH PULMONARY METASTASES</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>SEPSIS</p> | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier Timothy Low, M.D. | | | | 29c. License number D24034 | | 29d. Date signed (Month, Day, Year) 8/19/97 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIMOTHY LOW, M.D. 7620 YORK ROAD, TOWSON, MARYLAND 21204 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 21 1997 | | | | 32. Registrar's Signature Julia Davidson-Rodriguez | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 25217

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Mary Tews

2. Date of Death
Month Day Year

August 14 1997

3. Time of Death

3:00pm

4a. Facility Name (If not institution, give street and number)

Meridian Nursing Home

4b. City, Town, or Location of Death

Randallstown

4c. County of Death

Baltimore

5. Social Security Number

075-28-2231

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 15, 1904

9. Birthplace (State or Foreign Country)

Germany

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6003 Keithmont Court

10f. Zip Code

21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

6

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Home Maker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Friedrich Predat

18. Mother's Name (First, Middle, Maiden Surname)

Anna Kallweit

19a. Informant's Name/Relationship (Type, Print)

Irene N. Giguere (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6003 Keithmont Court Catonsville, Maryland 21228

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

St. John's Cemetery

Date

Aug. 18,

1997

20c. Location - City or Town, State

Westfield Massachusetts

21. Signature of Funeral Service Licensee

R. C. Witzke

22. Name and Address of Facility

Witzke Funeral Home of Catonsville, Inc.

1630 Edmondson Avenue Catonsville, Maryland 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a.

Due to (or as a consequence of):

aspiration pneumonia

2 wks

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b.

Due to (or as a consequence of):

end stage Alzheimer's disease

10 yrs

c.

Due to (or as a consequence of):

atherosclerotic disease

10 yrs

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

D. A. Allverne

29c. License number

D29769

29d. Date signed (Month, Day, Year)

8/14/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

marcelino D. Allverne

516 N. Rolling Rd Bn Hs.

31. Date filed (Month, Day, Year)

AUG 21 1997

32. Registrar's Signature

John Davidson

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-e show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25218

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>Claribel Vickers</u> | | | | 2. Date of Death Month <u>August</u> Day <u>19</u> Year <u>1997</u> | | 3. Time of Death <u>5:55pm</u> | |
| | 4a. Facility Name (If not institution, give street and number) <u>Franklin Square Hospital Center</u> | | | | 4b. City, Town, or Location of Death <u>Rosedale</u> | | 4c. County of Death <u>Baltimore</u> | |
| Funeral Director | 5. Social Security Number <u>212-32-1656</u> | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) <u>90</u> Yrs. | | 8. Date of Birth (Month, Day, Year) <u>July 8, 1907</u> | |
| | 9. Birthplace (State or Foreign Country) <u>Maryland</u> | | 10a. State <u>Maryland</u> | | 10b. County <u>Baltimore</u> | | 10c. City, Town or Location <u>Baltimore</u> | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number <u>3103 Glendale Ave.</u> | | 10f. Zip Code <u>21234</u> | | 10g. Citizen of What Country? <u>USA</u> | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <u>White</u> | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12 yrs</u> College (1-4 or 5+) <u>4 yrs</u> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Nurse</u> | | 16b. Kind of Business/Industry <u>Hospital</u> | | | |
| | 17. Father's Name (First, Middle, Last) <u>Percy Collins</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <u>Winnie E. Baker</u> | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) <u>Kay Shaw</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>8601 Pleasant Plains Rd. Towson, Md 21286</u> | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Parkwood Cemetery</u> | | 20c. Location - City or Town, State <u>Parkville, Maryland</u> | | 20d. Date <u>Aug 23 1997</u> | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee <u>Krista S. Wells</u> | | | | 22. Name and Address of Facility <u>Evans Chapel of Memories</u> <u>8800 Hartford Rd Baltimore, Md 21234</u> | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>Dissecting Aortic Aneurysm</u> Due to (or as a consequence of): <u>Atherosclerosis</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <u>20 min</u> <u>20 years</u> | | | | Approximate Interval Between Onset and Death <u>20 min</u> <u>20 years</u> | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury <u>M</u> | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier <u>Michael Suter</u> | | 29c. License number <u>D44604</u> | |
| To Be Completed by Physician/Medical Examiner | 29d. Date signed (Month, Day, Year) <u>8/21/97</u> | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Dr. Michael Suter 8100 Hartford Rd Baltimore, Maryland 21234</u> | | | | | |
| | 31. Date filed (Month, Day, Year) <u>AUG 21 1997</u> | | 32. Registrar's Signature <u>J. Davidson-Randall</u> | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25219

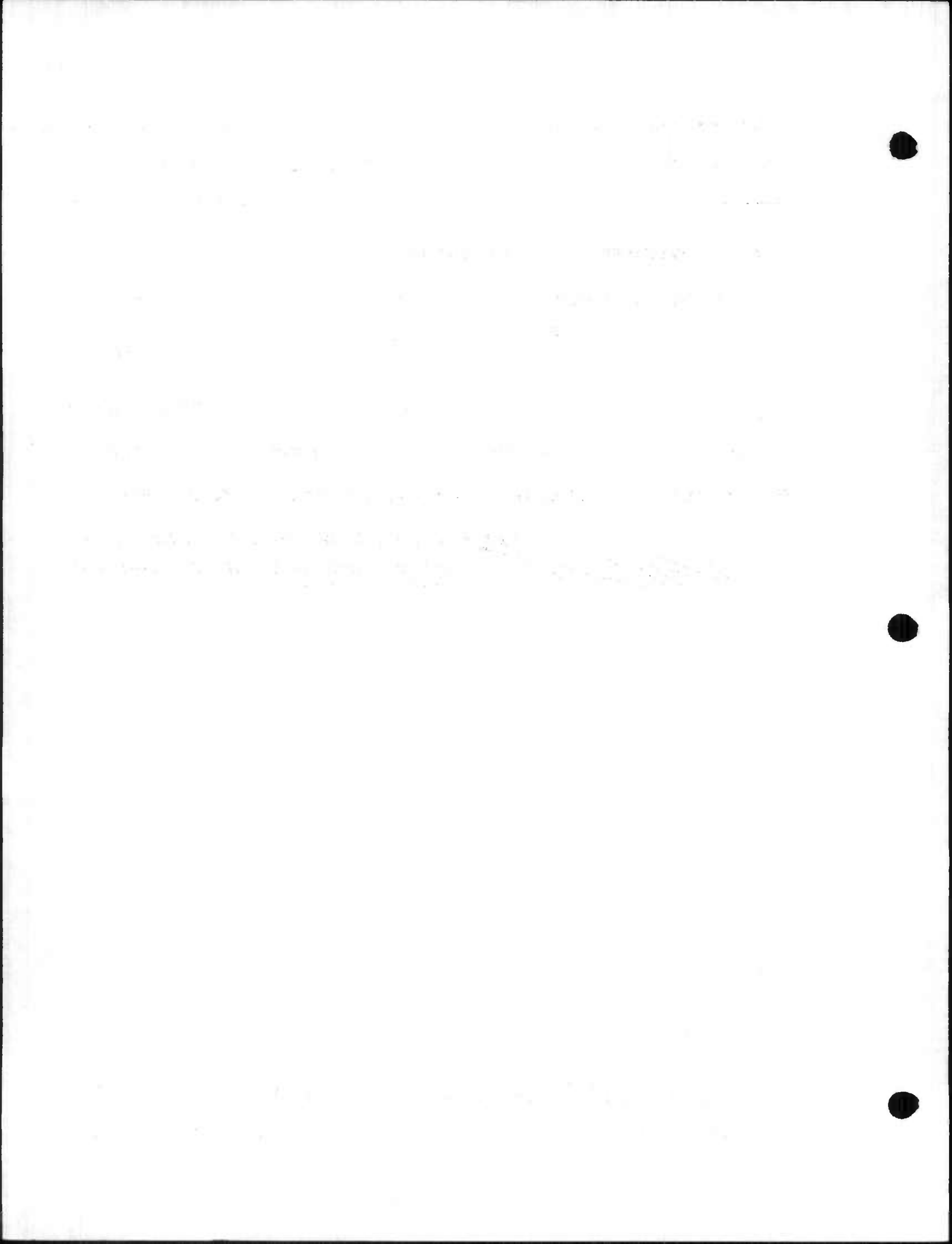
Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|---|---|---|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MARGARET HEINLEIN WINTER | | | | 2. Date of Death Month Day Year AUGUST 18 1997 | | 3. Time of Death 1:00 P.M. | |
| | 4a. Facility Name (If not institution, give street and number) COLLEGE MANOR, INC. | | | | 4b. City, Town, or Location of Death LUTHERVILLE | | 4c. County of Death BALTIMORE | |
| Funeral Director | 5. Social Security Number 219-16-6004 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 84 Yrs. | | 8. Date of Birth (Month, Day, Year) 11/03/12 | |
| | 9. Birthplace (State or Foreign Country) MARYLAND | | 10a. State MD | | 10b. County BALTIMORE | | 10c. City, Town or Location LUTHERVILLE | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 300 WEST SEMINARY AVENUE | | 10f. Zip Code 21093 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th GRADE College (1-4 or 5+) SUPERVISOR | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SUPERVISOR | | 16b. Kind of Business/Industry SOCIAL SECURITY | | | |
| | 17. Father's Name (First, Middle, Last) ADAM HEINLEIN | | | | 18. Mother's Name (First, Middle, Maiden Surname) ANNIE KAISER | | | |
| | 19a. Informant's Name/Relationship (Type, Print) PATRICIA NATALE DAUGHTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 BEDFORD DRIVE WEST TRENTON, NJ 08628 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MOST HOLY REDEEMER CEM. | | 20c. Date 8/22/97 | | 20d. Location - City or Town, State BALTIMORE, MD | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardio pulmonary Arrest Due to (or as a consequence of): b. Congestive Heart Failure Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 10 min. 4 y | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atrial Fibrillation Arteriosclerosis | | | | | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier William D. McConnell MD | | | | |
| 29c. License number D412129 | | | | 29d. Date signed (Month, Day, Year) 8-19-97 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 W. University | | | | 31. Date filed (Month, Day, Year) AUG 21 1997 | | | | |
| 32. Registrar's Signature John Davidson-Randall | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,




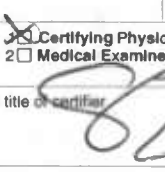

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25220

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|--|--|---|--|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) William Alfred Wood | | | | 2. Date of Death Month August Day 15 Year 1997 | | | | 3. Time of Death 4:45a.m. | |
| | 4a. Facility Name (If not institution, give street and number) 14705 Apt 103 Bowie Road | | | | 4b. City, Town, or Location of Death Laurel | | | | 4c. County of Death Prince George | |
| Funeral Director | 5. Social Security Number 289-30-2530 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 60 Yrs. | | 8. Date of Birth (Month, Day, Year) October 8, 1936 | | 9. Birthplace (State or Foreign Country) West Virginia | |
| | Usual Residence of Decedent | | | | 10e. State Maryland | | 10b. County Prince George | | 10c. City, Town or Location Laurel | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 10e. Street and Number 14705 Apt. 103 Bowie Road | | 10f. Zip Code 20708 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1953 1956 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 0 | | | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager of Vending | | | | 16b. Kind of Business/Industry Food | |
| | 17. Father's Name (First, Middle, Last) Clinton W. Wood | | | | 18. Mother's Name (First, Middle, Maiden Surname) Cecilia S. Reed | | | | | |
| | 19. Informant's Name/Relationship (Type, Print) Grace Wood/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14705 Apt 103 Bowie Road, Laurel, MD 20708 | | | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Washington Cr | | 20c. Date 8/16/97 | | 20d. Location - City or Town, State Laurel, Maryland | | | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) congestive heart failure Due to (or as a consequence of): chronic obstructive pulmonary disease Due to (or as a consequence of): diabetes Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last 3 years 3 years | | | | Approximate Interval Between Onset and Death 1 month 3 years | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) 8/15/97 | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier  | | | | 29c. License number 8890450 | | |
| | | | | 29d. Date signed (Month, Day, Year) 8/15/97 | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Eatra 7350 Van Dusen Rd Laurel MD 20707 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 21 1997 | | | | 32. Registrar's Signature  | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed with the cause of death. To the Funeral Director: After this certificate has been signed by the attending physician and completed in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25221

Item: 8, per Informant G-751 9/5/97 reb

Certificate of Death

Reg. No.

| | | | | | | | | | | | | |
|-------------------------------------|---|--|--|--|---|--|---|--|---|--|-------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Frank B. Winship | | | | 2. Date of Death Month August Day 18 Year 1997 | | | | 3. Time of Death 4:45 am | | | |
| | 4a. Facility Name (If not institution, give street and number) Suburban Hospital | | | | 4b. City, Town, or Location of Death Bethesda | | | | 4c. County of Death Montgomery | | | |
| Funeral Director | 5. Social Security Number 325-70-4705 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 49 Yrs. | | 8. Date of Birth (Month, Day, Year) Apr. 13, 1948 | | 9. Birthplace (State or Foreign Country) Pennsylvania | | | |
| | Usual Residence of Decedent | | | | 10a. State Md. | | 10b. County Howard | | 10c. City, Town or Location Laurel | | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number 9170 C Moonshine Hollow | | | | 10f. Zip Code 20723 | | | |
| | 10g. Citizen of What Country? USA | | | | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Grade 12 College (1-4 or 5+) | | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk | | | | 16b. Kind of Business/Industry U.S. Postal Service | | | | 17. Father's Name (First, Middle, Last) Clarence Gordon Winship | | | |
| | 18. Mother's Name (First, Middle, Maiden Surname) Stella Mae Barnett | | | | 19a. Informant's Name/Relationship (Type, Print) Stella Mae Winship / mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7810 Clark Road B-8 Jessup, Maryland 20794 | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc. | | | | 20c. Location - City or Town, State 8/19/97 Catonsville, Md. | | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Md. 20707 | | | | 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. SEPSIS | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | 24a. Were an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | |
| | 28a. Date of Injury (Month, Day Year) | | | | 28b. Time of Injury M | | | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| Physician /Medical Examiner | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier | | | | 29c. License number 141119 | | | |
| | 29d. Date signed (Month, Day, Year) August 18, 1997 | | | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DAYA SHAKMA 50 W. EDMONSTON DRIVE #303 Rockville Md 20852 | | | | 31. Date filed (Month, Day, Year) AUG 21 1997 | | 32. Registrar's Signature | |
| | 31. Date filed (Month, Day, Year) AUG 21 1997 | | | | 32. Registrar's Signature | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

NELLIE GRACE WALL
ASP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25222

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

NELLIE GRACE WALL

2. Date of Death

Month Day Year
AUGUST 15 1997

3. Time of Death

1931 P

4a. Facility Name (If not institution, give street and number)

HARFORD MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

HAVRE DE GRACE

4c. County of Death

HARFORD

Funeral
Director

5. Social Security Number

241-52-9947

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

61 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

MAY 11 1936

9. Birthplace (State or Foreign Country)

NORTH CAROLINA

Usual Residence of Decedent

10a. State

PENNSYLVANIA

10b. County

10c. City, Town or Location

PHILADELPHIA

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

20 S. 50th Street

10f. Zip Code

19139

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

PRIVATE DUTY NURSE

16b. Kind of Business/Industry

PATIENT CARE

17. Father's Name (First, Middle, Last)

ISIAH HARRINGTON

18. Mother's Name (First, Middle, Maiden Surname)

VIOLA WALL

19a. Informant's Name/Relationship (Type, Print)

Angela Wall/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20 S. 50th Street, Philadelphia, Pennsylvania 19139

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

FERNWOOD CEMETERY

Date

8-22-97

20c. Location - City or Town, State

FERNWOOD, PENNSYLVANIA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility WILLIAM C. BROWN COMMUNITY F/H
1206 W. NORTH AVENUE23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

Arteriosclerotic Cardiovascular Disease

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy
performed?

INSPECTION

☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☒ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
investigation
☐ Accident ☐ Could not be
determined
☐ Suicida ☐
☐ Homicida

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury et

Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☐ Certifying Physician☒ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

AUGUST 16, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen S. Radentz

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

AUG 21 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

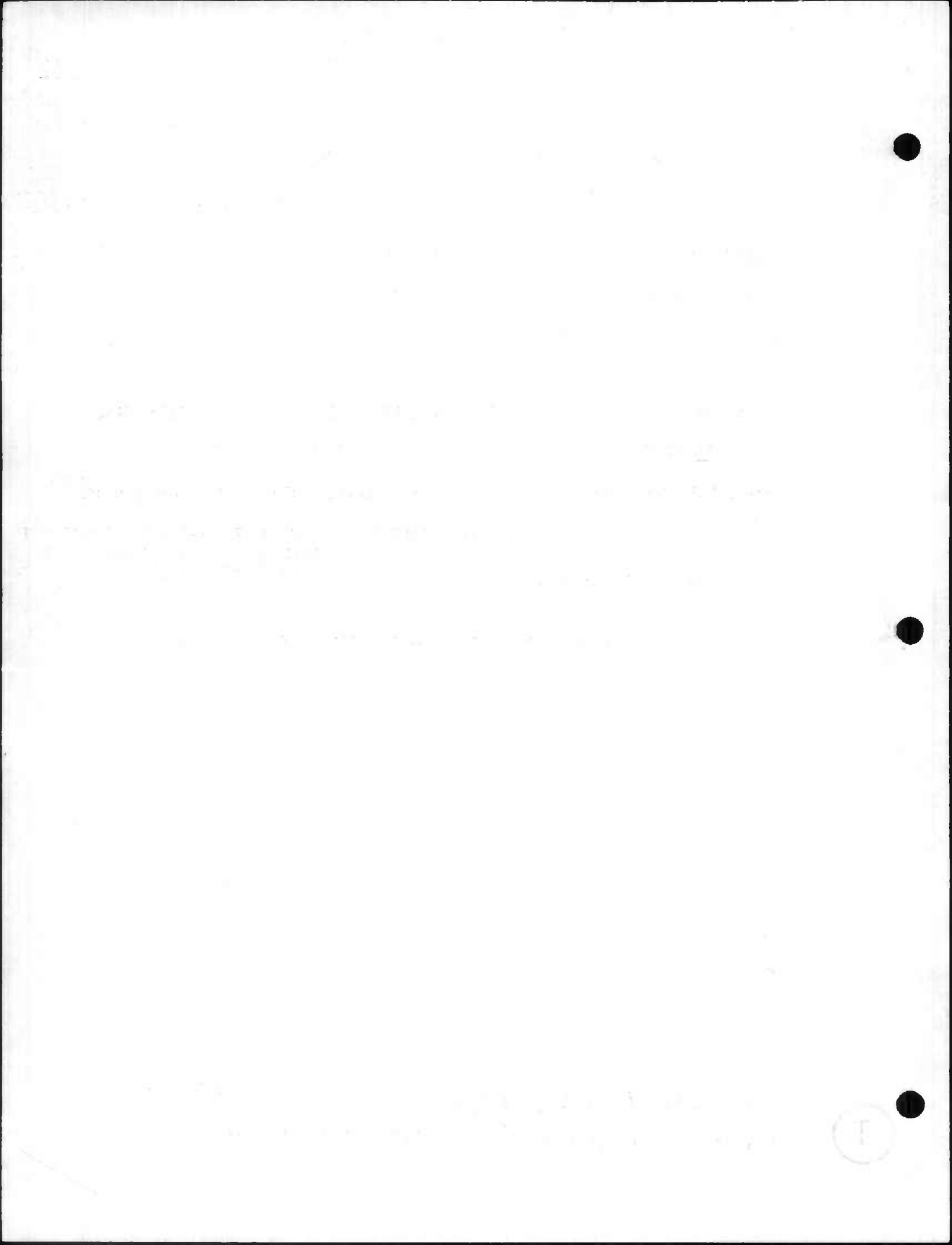
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director


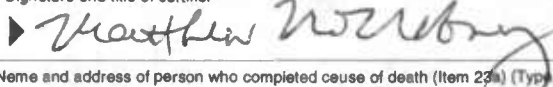



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25223

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|---|---|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) CHARLES W. WILSON | | | | 2. Date of Death Month AUG Day 19 Year 1997 | | 3. Time of Death 8:45AM | | |
| | 4a. Facility Name (If not institution, give street and number) LEVINDALE HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death BALTIMORE CITY | | 4c. County of Death N/A | | |
| Funeral Director | 5. Social Security Number 220-14-0163 | | 6. Sex XX M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 76 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) AUG. 18 1921 | 9. Birthplace (State or Foreign Country) VIRGINIA | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MARYLAND | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE CITY | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number 2836 VIRGINIA AVENUE | | | | 10f. Zip Code 21215 | | 10g. Citizen of What Country? U.S.A. | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 42/45 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th grade | | College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LPN | | 16b. Kind of Business/Industry HEALTH | | |
| | 17. Father's Name (First, Middle, Last) HARRY WILSON | | | | 18. Mother's Name (First, Middle, Maiden Surname) MARY GREEN | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Iva Wilson/ Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3409 Northern Pkwy, Baltimore, Maryland 21215 | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MARYLAND NATIONAL MEM PRK | | Date 8-22 | | 20c. Location - City or Town, State LAUREL, MARYLAND | | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility WILLIAM C. BROWN COMMUNITY F/H 1206 W. NORTH AVENUE | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ASPIRATION PNEUMONIA Due to (or as a consequence of): b. DEMENTIA Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last gortic aneurysm | | | | | | | Approximate interval between Onset and Death DAYS YRS | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. gortic aneurysm | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? N/A <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier  | | 29c. License number D45757 | | 29d. Date signed (Month, Day, Year) AUG 19, 1997 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MATTHEW McNABNEY 2434 W. BELLEVILLE BALTO, MD 21215 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 21 1997 | | 32. Registrar's Signature  | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25224

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EDEL TRAUT L. YASTRZEMSKY

2. Date of Death

Month Day Year
August 16 1997

3. Time of Death

2:05 PM

4a. Facility Name (If not institution, give street and number)

Harbor Hospital Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

214 38 5134

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

65

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 24, 1932

9. Birthplace (State or Foreign Country)

Poland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

1031 Bell Avenue

10f. Zip Code

21060

10g. Citizen of What Country?

U.S.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Home Maker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Otto Klump

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Greb

19a. Informant's Name/Relationship (Type, Print)

Vincent Yastrzemsky / husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1031 Bell Avenue Glen Burnie, Maryland 21060

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metro Crematory, Inc.

Date

8/18/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Richard C. Davis

22. Name and Address of Facility

Gonce Funeral Home P.A.

4001 Ritchie Highway Baltimore, Md. 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

a. Acute Respiratory Failure

3 days

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Non Small Cell carcinoma of the Lung

2 years

c. Chronic obstructive pulmonary disease

10 years

d. Congestive Heart Failure

4 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypothyroidism

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☒ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Amir Ouelletich, MD

29c. License number

AS 2441614-46

29d. Date signed (Month, Day, Year)

August 16 / 97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Amir Ouelletich, MD, 3001 S. Hanover St., Baltimore, MD 21225

31. Date filed (Month, Day, Year)

AUG 21 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

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any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25225

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ABRAM

ARNOPOLSKY

2. Date of Death

Month
JulyDay
29Year
1997

3. Time of Death

2345 P

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

378-15-2141

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

July 19, 1923

9. Birthplace (State or Foreign Country)

Russia

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

17226 King James Way #202

10f. Zip Code

20877

10g. Citizen of What Country?

Russia

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Director of Concert Hall

16b. Kind of Business/Industry

Entertainment

17. Father's Name (First, Middle, Last)

Yuda Arnopolsky

18. Mother's Name (First, Middle, Maiden Sumame)

Faina Chetsron

19a. Informant's Name/Relationship (Type, Print)

Muse Aliven/Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17136 King James Way #302 Gaithersburg, MD 20877

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Judean Memorial Gardens

Date

8/3/97

20c. Location - City or Town, State

Olney, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Edward Sagel Funeral Direction

1091 Rockville Pike Rockville MD 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 wks

b.

Cirrhosis of the Liver

Due to (or as a consequence of):

3 yrs

c.

Congestive Heart Failure

Due to (or as a consequence of):

2 weeks

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

History of Gastrointestinal Bleeding

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Wilkinson J. Ninala

29c. License number

D45285

29d. Date signed (Month, Day, Year)

July 30, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wilkinson J. Ninala 18111 Prince Phillip Dr. 212 Olney, MD 20832

31. Date filed (Month, Day, Year)

AUG 01 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25226

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|---|---------------------------|---|---|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Anne Baker Ashland | | | | | | 2. Date of Death Month Day Year July 26, 1997 | | 3. Time of Death 3:00AM | |
| | 4a. Facility Name (If not Institution, give street and number) Suburban Hospital | | | | | | 4b. City, Town, or Location of Death Bethesda | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 577-34-5077 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 69 Yrs. | | 8. Date of Birth (Month, Day, Year) Aug. 14, 1927 | | 9. Birthplace (State or Foreign Country) Washington, DC | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Kensington | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 4413 Glenridge Street | | | | 10f. Zip Code 20895 | | 10g. Citizen of What Country? United States | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher | | | 16b. Kind of Business/Industry Education | | | |
| 17. Father's Name (First, Middle, Last) Lewis Baker, Sr. | | | | | | 18. Mother's Name (First, Middle, Maiden Summa) Emily Light | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Roger D. Ashland/Husband | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4413 Glenridge Street, Kensington, Maryland 20895 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Rock Creek Cemetery | | Date July 29, 1997 | | 20c. Location - City or Town, State Washington, D.C. | | |
| 21. Signature of Funeral Service Licensee Daniel E. Perry M00803 | | | | 22. Name and Address of Facility Robert A. Pumphrey Funeral Home Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death) | | | | | | | | | | |
| a. Sepsis Due to (or as a consequence of): | | | | | | | | | | |
| b. Anastamotic Failure Due to (or as a consequence of): | | | | | | | | | | |
| c. Total Gastrectomy Due to (or as a consequence of): | | | | | | | | | | |
| d. Metastatic Gastric Carcinoma | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Respiratory Failure | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier Ernest D. Hanowell | | | | 29c. License number D21898 | | 29d. Date signed (Month, Day, Year) July 29, 1997 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ernest D. Hanowell, M.D. 10401 Old Georgetown Road, Bethesda, MD 20814 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 01 1997 | | | | 32. Registrar's Signature John Davidson | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

10

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25227

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Frank H. Attix

2. Date of Death

Month Day Year
July 25, 1997

3. Time of Death

12:32 pm

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

559-22-7142

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

72

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
April 2, 1925

9. Birthplace (State or Foreign Country)

Oregon

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

705 Kent Oaks Way

10f. Zip Code

20878

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☐ No

If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Medical Physicist

16b. Kind of Business/Industry

Medical Research

17. Father's Name (First, Middle, Last)

Ulysses Sheldon Attix

18. Mother's Name (First, Middle, Maiden Summa)

Alma Mickelsen

19a. Informant's Name/Relationship (Type, Print)

Richard H. Attix / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

705 Kent Oaks Way, Gaithersburg, MD 20878

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Sunset Memory Gardens

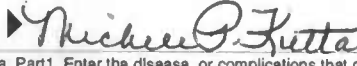
Date

Aug. 1, 1997

20c. Location - City or Town, State

Madison, Wisconsin

21. Signature of Funeral Service Licensee



M00348

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc., 7557 Wisconsin Ave.
Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute posterior wall myocardial infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

N/A

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No25. Was case referred to medical examiner?
☐ Yes ☒ No

Hospital:

☐ Inpatient ☒ ER/Outpatient ☐ DOA

Other:

26. Place of Death (Check only one)

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

 SACHDEV, M.D.

29c. License number

D46741

29d. Date signed (Month, Day, Year)

July 25, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deepak Sachdeva

9901 medical center Drive

Rockville, MD 20850

31. Date filed (Month, Day, Year)

JUL 30 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

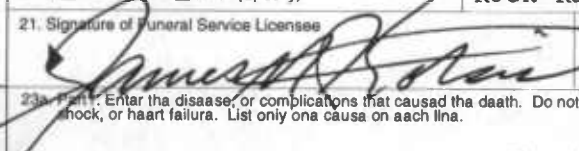
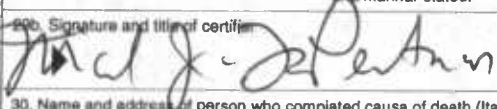
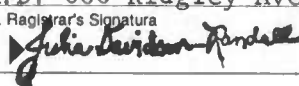
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25228

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|--|---|--|--|--|---|--|--|--|---|---|--|
| Physician /Medical Examiner | 1. Decedant's Name (First, Middle, Last) Elizabeth Nowlin Anderson | | | | | | 2. Date of Death Month Day Year August 4 1997 | | 3. Time of Death 6:55 PM | | |
| | 4a. Facility Name (If not institution, give street and number) Genesis Elder Care Center, Spa Creek | | | | | | 4b. City, Town, or Location of Death Annapolis | | 4c. County of Death Anne Arundel | | |
| Funeral Director | 5. Social Security Number 214-40-4006 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 95 Yrs. | | 8. Date of Birth (Month, Day, Year) Oct 4 1901 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| | 10a. State MD | | 10b. County Anne Arundel | | 10c. City, Town or Location Annapolis | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | |
| To Be Completed by Funeral Director | 10e. Street and Number 1724 Woodlore Road | | 10f. Zip Code 21401 | | 10g. Citizen of What Country? United States | | 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedant Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | |
| | 13. Was Decedant of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedant's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collega (1-4 or 5+) 6 | | 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher | | 16b. Kind of Business/Industry Education | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Samuel W. Anderson | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Anna Chesney | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Betty Baird (Niece) | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1724 Woodlore Road Annapolis, Maryland 21401 | | | | |
| Physician /Medical Examiner | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Rock Run Cemetery August 7, 1997 | | 20c. Location - City or Town, State Level, Maryland | | 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 | | |
| | 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CVA Dua to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): | | | | | | Approximate Interval Between Onset and Death 6h | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | 28. Place of Death (Check only one) Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 8 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier  | | 29c. License number D21438 | |
| 29d. Date signed (Month, Day, Year) August 5, 1997 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael J. LaPenta, M.D. 600 Ridgley Avenue Annapolis, MD 21401 (410-224-0070) | | 31. Data filed (Month, Day, Year) AUG 06 1997 | | 32. Registrar's Signature  | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

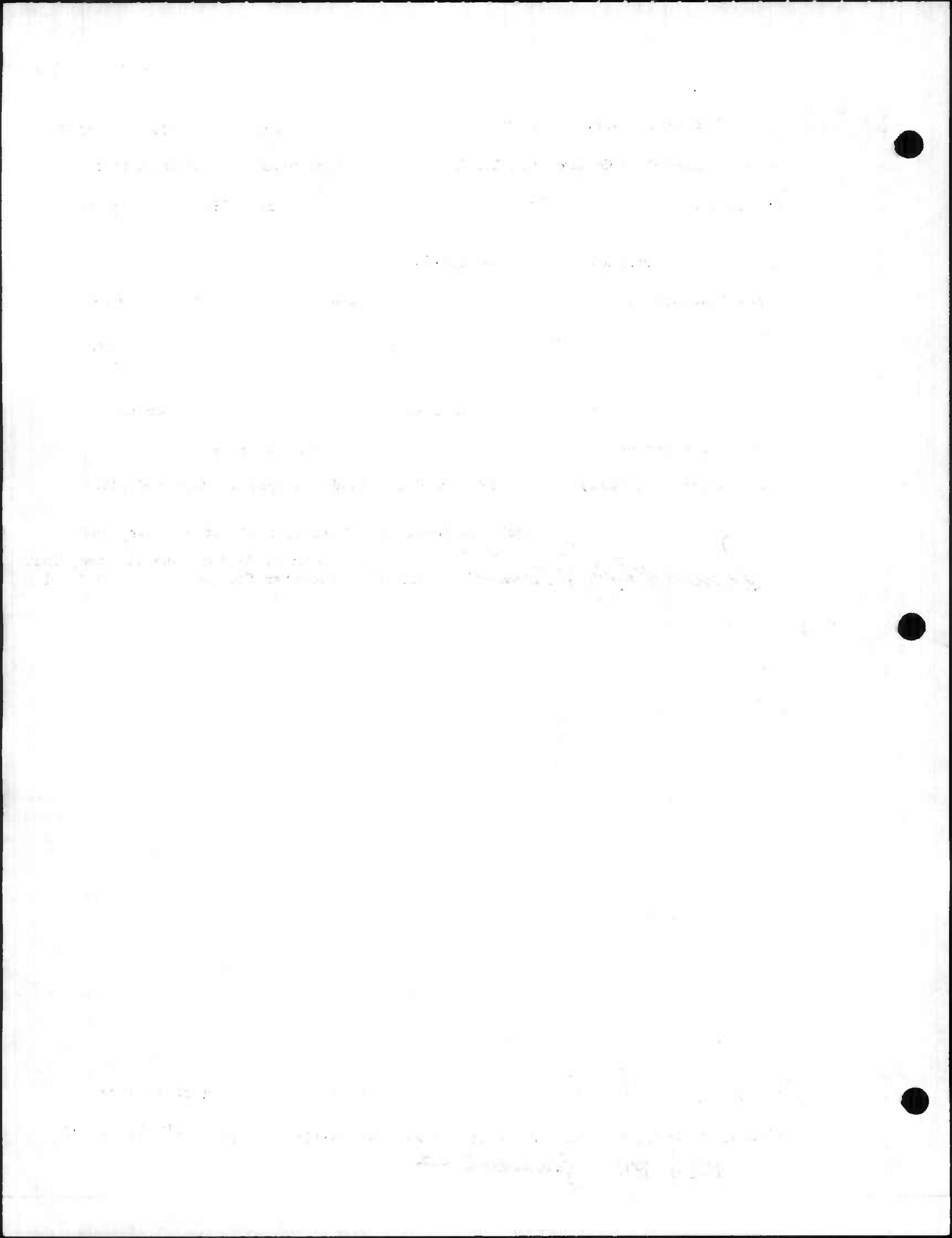
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25229

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Orhan H. Aydinel

2. Date of Death

August 5, 1997

3. Time of Death

6:00 a.m.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

705 Braeburn Drive

4b. City, Town, or Location of Death

Fort Washington

4c. County of Death

Prince George's

5. Social Security Number

577-52-8143

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

July 22, 1922

9. Birthplace (State or Foreign Country)

Turkey

Usual Residence of Decedent

10a. State
Maryland10b. County
Prince George's10c. City, Town or Location
Fort Washington

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

705 Braeburn Drive

10f. Zip Code

20744

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

18a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Medical Doctor

16b. Kind of Business/Industry

Medicine

17. Father's Name (First, Middle, Last)

Suheyb Aydinel

18. Mother's Name (First, Middle, Maiden Surname)

Unknown

Unknown

19a. Informant's Name/Relationship (Type, Print)

Elizabeth Aydinel/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

705 Braeburn Dr., Ft. Washington, Md. 20744

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Ft. Lincoln Cemetery

Date

8/7/97

20c. Location - City or Town, State

Brentwood, Md.

21. Signature of Funeral Service Licensee

George P. Kalas

22. Name and Address of Facility

George P. Kalas Funeral Home
6160 Oxon Hill Rd. Oxon Hill, Md. 2074523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. ARTERIOSCLEROTIC CEREBROVASCULAR DISEASE

Due to (or as a consequence of):

b. Multiple cerebral infarctions

Due to (or as a consequence of):

c. Hypertensive cerebral vascular disease

Due to (or as a consequence of):

d. Renal Failure

Sequentially list conditions,
if any, leading to immediate
cause. Enter underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Decubital ulcers

Arteriosclerotic Heart Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No28d. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28e. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

R. McConaughy MD

29c. License number

D07287

29d. Date signed (Month, Day, Year)

8-5-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R. McConaughy MD 11418 Livingston Rd Fort Washington Md 20744

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

John A. Dwyer

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25230

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | |
|---|---|---|---|--|--|--|--|---|---|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) CORA LEE ALSTON | | | | 2. Date of Death Month August Day 02 , Year 1997 | | 3. Time of Death 7:30 p.m. | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) FORT WASHINGTON HOSPITAL | | | | 4b. City, Town, or Location of Death FORT WASHINGTON | | 4c. County of Death PRINCE GEORGES | | | | | | | |
| Funeral Director | 5. Social Security Number 242-24-3521 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 84 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) December 12, 1912 | 9. Birthplace (State or Foreign Country) North Carolina | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Prince George's | | 10c. City, Town or Location Oxon Hill | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| | 10e. Street and Number 560 Wilson Bridge Drive | | | | 10f. Zip Code 20745 | | 10g. Citizen of What Country? U.S.A. | | | | | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dietician | | 16b. Kind of Business/Industry Government | | | | | | | |
| | 17. Father's Name (First, Middle, Last) Walter Alston | | | | 18. Mother's Name (First, Middle, Maiden Surname) Penny Askew | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Nathaniel Alston/Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 123 Carver Court, Coatesville, Pennsylvania 19320 | | | | | | | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) New Evergreen Cemetery | | Date 08/08 1997 | | 20c. Location - City or Town, State Coatesville, PA | | | | | | | |
| | 21. Signature of Funeral Service Licensee Nancy A. Perceuthe | | | | 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785 | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | |
| | <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td rowspan="4"> { </td> <td>a. Diabetes Mellitus Due to (or as a consequence of):</td> <td rowspan="4"> Approximate Interval Between Onset and Death Years </td> </tr> <tr> <td>b. Due to (or as a consequence of):</td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | { | a. Diabetes Mellitus Due to (or as a consequence of): | Approximate Interval Between Onset and Death Years | b. Due to (or as a consequence of): | c. Due to (or as a consequence of): |
| Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | { | a. Diabetes Mellitus Due to (or as a consequence of): | Approximate Interval Between Onset and Death Years | | | | | | | | | | | |
| | | b. Due to (or as a consequence of): | | | | | | | | | | | | |
| | | c. Due to (or as a consequence of): | | | | | | | | | | | | |
| | | d. Due to (or as a consequence of): | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Seizure disorder; Multiple Cerebrovascular Accidents | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how Injury occurred | | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier [Signature] | | 29c. License number D12906 | | 29d. Date signed (Month, Day, Year) 8/13/97 | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. Louis V. Kaufman, 8926 Woodyard Rd, Clinton, MD 20735 | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) August 03, 1997 | | 32. Registrar's Signature John Anderson-Randall | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25231

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William Sidney Balderson

2. Date of Death

August 5 1997

3. Time of Death

10:55 AM

4e. Facility Name (If not institution, give street and number)

Citizens Nursing Home

4b. City, Town, or Location of Death

Havre de Grace

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

212-07-6098

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

93

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

2/6/1904

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Md.

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

803 Cashew Court

Apt. F

10f. Zip Code

21014

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Caucasian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Lineman

16b. Kind of Business/Industry

Baltimore Gas Electric Co.

17. Father's Name (First, Middle, Last)

Joseph Octavus Balderson

18. Mother's Name (First, Middle, Maiden Surname)

Sidney Erminnie Wilkerson

19a. Informant's Name/Relationship (Type, Print)

Phyllis M. Mitchell/Rep.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

same as #10

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Carroll Cremation

Date

8/8/97

20c. Location - City or Town, State

Hampstead, Maryland

21. Signature of Funeral Service Licensee

M. Bladden Kurtz III

22. Name and Address of Facility

Kurtz Funeral Home, P.A.
Jarrettsville, Maryland

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Lymphoma

Approximate Interval Between Onset and Death

2 months

Due to (or as a consequence of):

congestive heart failure

5 days

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Ca Prostate with metastasis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier

William M.D.

29c. License number

D32609

29d. Date signed (Month, Day, Year)

8/5/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kammichan Mullan MD 703 Revolution St Havre De Grace MD 21078

31. Date filed (Month, Day, Year)

AUG 8 1997

32. Registrar's Signature

John A. Baskin

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25232

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Daniel S. Berezne

2. Date of Death

Month Day Year
AUGUST 03 1997 01:42

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Fallston General Hospital

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

5. Social Security Number

219-20-6111

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

9/21/26

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

PA

10b. County

York

10c. City, Town or Location

Delta

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

276 Ailes Road

10f. Zip Code

17314

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:
WW 2

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:
White15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Longshoreman

16b. Kind of Business/Industry

Shipping

17. Father's Name (First, Middle, Last)

John T. Berezne

18. Mother's Name (First, Middle, Maiden Surname)

Zuzanna Yabczynski

19a. Informant's Name/Relationship (Type, Print)

Catherine M. Berezne-wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

276 Ailes Rd., Delta, PA 17314

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Stanislaus

Date

8/6/97

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

John D. Tillet

22. Name and Address of Facility

Harkins F.H. Inc., Delta, PA 17314

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Minutes

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of injury

(Month, Day Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Scott Haswell MD

29c. License number

D34652

29d. Date signed (Month, Day, Year)

August 3, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Scott Haswell 2 NORTH AVE BEL AIR MARYLAND 21014

31. Date filed (Month, Day, Year)

AUG 6 1997

32. Registrar's Signature

John D. Tillet

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10X1

97 25233

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Walter Bond | | | | 2. DATE OF DEATH MONTH 8 DAY 2 YEAR 97 | | 3. TIME OF DEATH 1 PM | |
| 4. SOCIAL SECURITY NUMBER 217-14-2877 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 8. AGE (In yrs. last birthday) 79 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) June 20, 1918 | |
| 9a. FACILITY NAME (If not institution, give street and number) Brevins Nursing Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Havre de Grace | | 9c. COUNTY OF DEATH Harford | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Harford | | 10c. CITY, TOWN OR LOCATION Aberdeen | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 760 Battle Avenue | | | | 10f. ZIP CODE 21001 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4 or 5+) 0 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laborer | | 16b. KIND OF BUSINESS/INDUSTRY State Roads | | | |
| 17. FATHER'S NAME (First, Middle, Last) George Bond | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) May Thomas | | | |
| 19a. INFORMANT'S NAME (Type/Print) Asbury E. Bond | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 760 Battle Ave., Aberdeen, Maryland 21001 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Calvary Cemetery | | 20c. LOCATION — City or Town, State Aberdeen, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kersten Amy Unglesbee | | | | 22. NAME AND ADDRESS OF FACILITY Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| a. Dehydration DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | 10 days |
| b. upper Gastrointestinal bleed DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | 1 month |
| c. CA Prostate & Metastasis DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | 5 year |
| d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Coronary Artery Disease | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER B249 MIRZA A BAIG MD | | | | | |
| | | 29c. LICENSE NUMBER D43115 | | 29d. DATE SIGNED (Month, Day, Year) 8-4-97 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 615 S. Union Ave., Havre De Grace, MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) AUG 5 1997 | | 32. REGISTRAR'S SIGNATURE Jebia Dandekar Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25234

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Helen Ann Brown

2. Date of Death

Month

Day

Year

August 10 1997

3. Time of Death

8:30 AM

4a. Facility Name (If not institution, give street and number)

Calvert Manor Healthcare Center

4b. City, Town, or Location of Death

Rising Sun

4c. County of Death

Cecil

Funeral
Director

5. Social Security Number

578-48-4085

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

May 11, 1904

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Rising Sun

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1881 Telegraph Rd

10f. Zip Code

21911

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

unknown

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Boarding House

17. Father's Name (First, Middle, Last)

Charles Alexander Hutchens

18. Mother's Name (First, Middle, Maiden Surname)

Amelia C. Sensibaugh

19a. Informant's Name/Relationship (Type, Print)

Ruth Butler/power of attorney

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

107 Daleville Rd. Cochranville, PA 19330

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Brookview Cemetery

Date

Aug. 14, 1997

20c. Location - City or Town, State

Rising Sun, MD

21. Signature of Funeral Service Licensee

Richard L. Goodie

22. Name and Address of Facility

R. T. Foard Funeral Home

111 S. Queen St.

Rising Sun, MD 21911

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 wks

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypertensive ASCVD

Due to (or as a consequence of):

5 yrs

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dudley Phillips MD

29c. License number

D09428

29d. Date signed (Month, Day, Year)

8/11/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dudley Phillips MD

P.O. Box 300

Darlington Md 21034

31. Date filed (Month, Day, Year)

8/11/97

32. Registrar's Signature

AUG 11 1997

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25235

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERT BART

2. Date of Death

Month Day Year
JULY 26, 1997

3. Time of Death

11:12PM

4a. Facility Name (If not institution, give street and number)

HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

083-24-4218

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
MAY 23, 1930

9. Birthplace (State or Foreign Country)

NYC

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

905 BRENTWOOD LANE

10f. Zip Code

20902

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

OPERATIONS RESEARCH ANALYST

16b. Kind of Business/Industry

DEPT. OF EDUCATION

17. Father's Name (First, Middle, Last)

LOUIS BART

18. Mother's Name (First, Middle, Maiden Surname)

SALLIE KAHME

19a. Informant's Name/Relationship (Type, Print)

FRIEDA BART / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

905 BRENTWOOD LANE, SILVER SPRING, MD 20902

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BETH DAVID CEMETERY

Date

7/28/97

20c. Location - City or Town, State

ELMONT, NY

21. Signature of Funeral Service Licensee

DANIEL SIMONS

22. Name and Address of Facility

EDWARD SAGEL FUNERAL DIRECTION, INC.
1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIOGENIC SHOCK

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

MINUTES

b. MYOCARDIAL INFARCTION - ACUTE

Due to (or as a consequence of):

MINUTES

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RECENT PULMONARY EMBOLI

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☒ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Raymond M. White

29c. License number

D43539

29d. Date signed (Month, Day, Year)

July 27, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAYMOND M. WHITE, MD, 1500 FOREST GLEN RD., HOLY CROSS HOSPITAL, SILVER SPRING, MD

31. Date filed (Month, Day, Year)

JUL 29 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25236

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|----------------------------------|---|---|--|---|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Florence A. Brockwell | | | | | | 2. Date of Death Month Day Year July 26, 1997 | | 3. Time of Death 10:10 AM | |
| | 4a. Facility Name (If not Institution, give street and number) Rockville Nursing Home | | | | | | 4b. City, Town, or Location of Death Rockville | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 579-54-9786 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 92 Yrs. | | 8. Date of Birth (Month, Day, Year) March 11, 1905 | | 9. Birthplace (State or Foreign Country) Virginia | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Rockville | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 6829 Old Stage Road | | | | 10f. Zip Code 20852 | | 10g. Citizen of What Country? U.S.A. | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | 16b. Kind of Business/Industry Own Home | | | |
| 17. Father's Name (First, Middle, Last) Zetie Damron | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Maggie O'Brian | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Glenna M. McClanahan | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6829 Old Stage Road Rockville, Maryland 20852 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery | | | Date 7/29/97 | | 20c. Location - City or Town, State Brentwood, Maryland | | |
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | | | 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CONGESTIVE HEART FAILURE Due to (or as a consequence of): Arteriosclerotic HEART DISEASE Approximate Interval Between Onset and Death 2 months, 10 years | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | 29b. Signature and title of certifier <i>[Signature]</i> | | 29c. License number D1521 | | 29d. Date signed (Month, Day, Year) 7-28-97 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN A. GALOTTE, M.D. 5225 Pooks Hill Road #1 Bethesda, Maryland 20814 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 29 1997 | | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

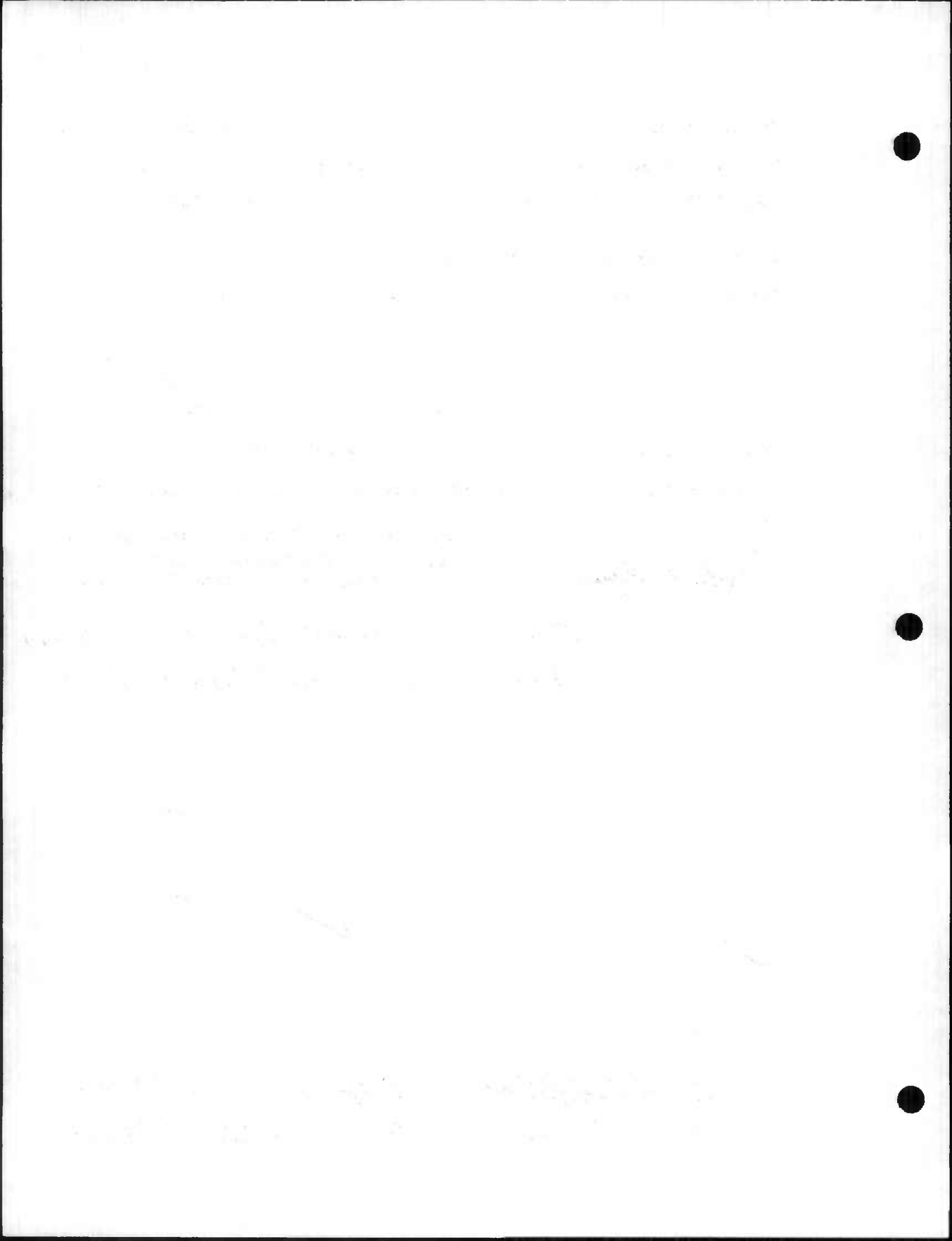
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at 50558.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit certificate.

6



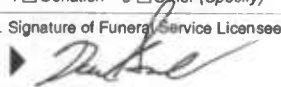

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25237

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|--|--|--|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) LILLIAN BROWN. | | | | 2. Date of Death Month JULY Day 26 Year 1997 | | 3. Time of Death 6:30AM | |
| | 4a. Facility Name (If not institution, give street and number) HEBREW HOME OF GREATER WASHINGTON | | | | 4b. City, Town, or Location of Death ROCKVILLE | | 4c. County of Death MONTGOMERY | |
| Funeral Director | 5. Social Security Number 336-05-0682 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 89 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) JUNE 12, 1908 | 9. Birthplace (State or Foreign Country) OHIO |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County MONTGOMERY | | 10c. City, Town or Location ROCKVILLE | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 6121 MONTROSE RD. | | | | 10f. Zip Code 20852 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSE WIFE | | 16b. Kind of Business/Industry OWN HOME | | |
| 17. Father's Name (First, Middle, Last) NATHAN RICHMAN | | | | 18. Mother's Name (First, Middle, Maiden Surname) SYLVIA LIFSHITZ | | | | |
| 19a. Informant's Name/Relationship (Type, Print) ELINOR FLYER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11204 MARCLIFF RD., ROCKVILLE, MD 20852 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MENORAH GARDENS | | Date 7/27/97 | | 20c. Location - City or Town, State ROCKVILLE, MD | | |
| 21. Signature of Funeral Service Licensee  DANIEL SIMONS | | | | 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Congestive Heart Failure. Due to (or as a consequence of): b. hypertension Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Cerebrovascular Accident | | | | | | | | Approximate Interval Between Onset and Death 3 yrs. 10 yrs. |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebrovascular Accident | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier  | | 29c. License number D37891 | | 29d. Date signed (Month, Day, Year) July 26 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARAVANSHI MD 121 Congressional Ln #409 Rockville MD 20852 | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 29 1997 | | 32. Registrar's Signature  | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25238

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|---|---|---|---|--|---|--|----|---------------------------------|---|----|-----------------------|---|---|----|--|--|--|--|--|--|--|--|---------------------------------|--|--|--|--|--|--|--|-----------------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--------------------------------------|--|--|--|---|--|---|--|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) CAROL S. BURGESS | | | | 2. Date of Death Month July Day 23 Year 1997 | | 3. Time of Death 6:20 PM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) 16108 Crabbs Branch Way | | | | 4b. City, Town, or Location of Death Rockville | | 4c. County of Death Montgomery | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 214-22-7538 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 71 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) July 28, 1925 | | 9. Birthplace (State or Foreign Country) Maryland | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | 10b. County Montgomery | | 10c. City, Town or Location Rockville | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 10e. Street and Number 16108 Crabbs Branch Way | | | 10f. Zip Code 20855 | | 10g. Citizen of What Country? U.S.A. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th Collage (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Receptionist | | | 16b. Kind of Business/Industry U.S. Government | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last) Andrew W. Dorsey | | | | 18. Mother's Name (First, Middle, Maiden Surname) Florence Powell | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Regina Burgess (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17125 Queen Victoria Ct., Gaithersburg, MD 20877 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Bushy Park Cemetery | | Date 7/30/97 | | 20c. Location - City or Town, State Cooksville, MD | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee <i>George R. Snowden</i> | | | | 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>Congestive Heart failure</td> <td rowspan="4">Approximate Interval Between Onset and Death acute & chronic</td> </tr> <tr> <td>b.</td> <td>Cardiomyopathy</td> </tr> <tr> <td>c.</td> <td>Rheumatoid Heart Disease</td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. | Congestive Heart failure | Approximate Interval Between Onset and Death acute & chronic | b. | Cardiomyopathy | c. | Rheumatoid Heart Disease | d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | a. | Congestive Heart failure | Approximate Interval Between Onset and Death acute & chronic | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | b. | Cardiomyopathy | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | c. | Rheumatoid Heart Disease | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="1"> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td colspan="3">23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</td> </tr> <tr> <td colspan="3">24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> </tr> <tr> <td colspan="3">24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> <td></td> </tr> </table> | | | | | | | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="1"> <tr> <td colspan="4">Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SPO - aortic & mitral valve disease X2</td> </tr> <tr> <td colspan="4">25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> </tr> <tr> <td colspan="4">26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</td> </tr> <tr> <td colspan="2">27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined</td> <td colspan="2">28a. Date of Injury (Month, Day, Year)</td> </tr> <tr> <td colspan="2"></td> <td colspan="2">28b. Time of Injury M</td> </tr> <tr> <td colspan="2"></td> <td colspan="2">28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> </tr> <tr> <td colspan="2"></td> <td colspan="2">28d. Describe how Injury occurred</td> </tr> <tr> <td colspan="2"></td> <td colspan="2">28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</td> </tr> <tr> <td colspan="2"></td> <td colspan="2">28f. Location (Street and Number or Rural Route Number, City or Town, State)</td> </tr> <tr> <td colspan="4">29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</td> </tr> <tr> <td colspan="2">29b. Signature and title of certifier <i>John S. Sava MD</i></td> <td colspan="2">29c. License number D10493</td> </tr> <tr> <td colspan="2"></td> <td colspan="2">29d. Date signed (Month, Day, Year) July 24, 1997</td> </tr> <tr> <td colspan="4">30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J.S. SAIA, MD 809 Viens Mill Rd Rock. MD 20851</td> </tr> <tr> <td colspan="2">31. Date filed (Month, Day, Year) JUL 28 1997</td> <td colspan="2">32. Registrar's Signature <i>Julia Davidson-Pendell</i></td> </tr> </table> | | | | | | | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SPO - aortic & mitral valve disease X2 | | | | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | | | 28b. Time of Injury M | | | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 28d. Describe how Injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier <i>John S. Sava MD</i> | | 29c. License number D10493 | | | | 29d. Date signed (Month, Day, Year) July 24, 1997 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J.S. SAIA, MD 809 Viens Mill Rd Rock. MD 20851 | | | | 31. Date filed (Month, Day, Year) JUL 28 1997 | | 32. Registrar's Signature <i>Julia Davidson-Pendell</i> | |
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| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | 28b. Time of Injury M | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | 28d. Describe how Injury occurred | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier <i>John S. Sava MD</i> | | 29c. License number D10493 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | 29d. Date signed (Month, Day, Year) July 24, 1997 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J.S. SAIA, MD 809 Viens Mill Rd Rock. MD 20851 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 28 1997 | | 32. Registrar's Signature <i>Julia Davidson-Pendell</i> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

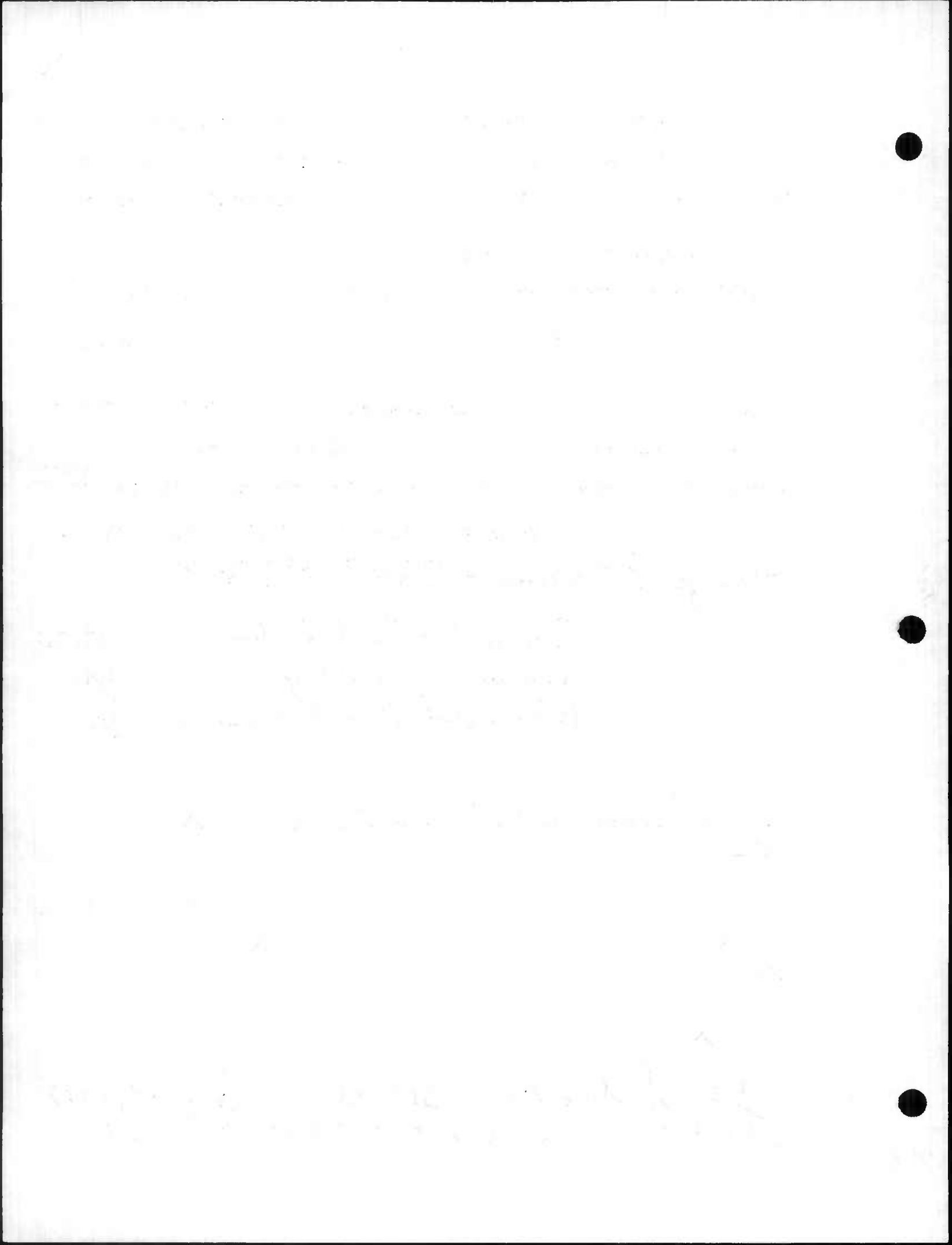
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



97 25239

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Isabel Brogan</i> | | | | 2. DATE OF DEATH MONTH <i>8</i> DAY <i>4</i> YEAR <i>97</i> | | 3. TIME OF DEATH <i>4AM</i> M | |
| 4. SOCIAL SECURITY NUMBER <i>045 14 4187</i> | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 8. AGE (In yrs. last birthday) <i>84</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>04/05/1913</i> | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>Annapolis Nursing & Rehabilitation</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Annapolis</i> | | 9c. COUNTY OF DEATH <i>Anne Arundel</i> | |
| 10a. STATE <i>FL</i> | | 10b. COUNTY <i>Pasco</i> | | 10c. CITY, TOWN OR LOCATION <i>New Port Richey</i> | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <i>6909 Springflower Drive</i> | | | | 10f. ZIP CODE <i>34655</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>4</i> College (1-4 or 5+) <i>4</i> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>School Teacher</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>Education</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>William Brower</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Rilla Not Available</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Jesse Brogan (son)</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>70 Tarragon Lane, Edgewater MD 21037-1103</i> | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Metropolitan Crematory 8/6</i> | | 20c. LOCATION — City or Town, State <i>Alexandria VA</i> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael Nagene</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Advent Funeral & Cremation Services Annapolis MD 21401</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Stroke</i> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <i>Hypertension</i> DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | Approximate Interval Between Onset and Death <i>5 days</i> <i>many years</i> | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>R. L. Hochman, MD</i> | | | | 29c. LICENSE NUMBER <i>DO 5192</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>8/4/97</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Richard I. Hochman, MD 1833 A Forest Dr., Annapolis, Md. 21401</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>AUG 05 1997</i> | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 8 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25240
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lawrence C. Baker

2. Date of Death

Aug 4 1997 0050

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

212-08-0450

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

26 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

NOV. 14 1970

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

ANNAPOLIS

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

619 TUCKERHOLE CREEK COURT

10f. Zip Code

21401

10g. Citizen of What Country?

US

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

10th

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CUSTODIAN

16b. Kind of Business/Industry

McDONALDS

17. Father's Name (First, Middle, Last)

LAWRENCE C. BAKER SR.

18. Mother's Name (First, Middle, Maiden Surname)

LEOLA OFFER

19a. Informant's Name/Relationship (Type, Print)

LEOLA BAKER (MOTHER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

619 TUCKERHOLE CREEK COURT ANNAPOLIS, MD. 21401

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

OFFER CEMETERY

Date

8/8/97

20c. Location - City or Town, State

CHURCHTON, MD.

21. Signature of Funeral Service Licensee

Harry D. Reese

22. Name and Address of Facility

WM. REESE & SONS MORTUARY, P.A.
821 WEST ST. ANNAPOLIS, MD. 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. cardiomyopathy

Due to (or as a consequence of):

b. hypertension

Due to (or as a consequence of):

c. obesity

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jeffrey Suggs MD

29c. License number

D28640

29d. Date signed (Month, Day, Year)

August 4, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

2414 Hightee Ct. Crofton MD 21114

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

Jana Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

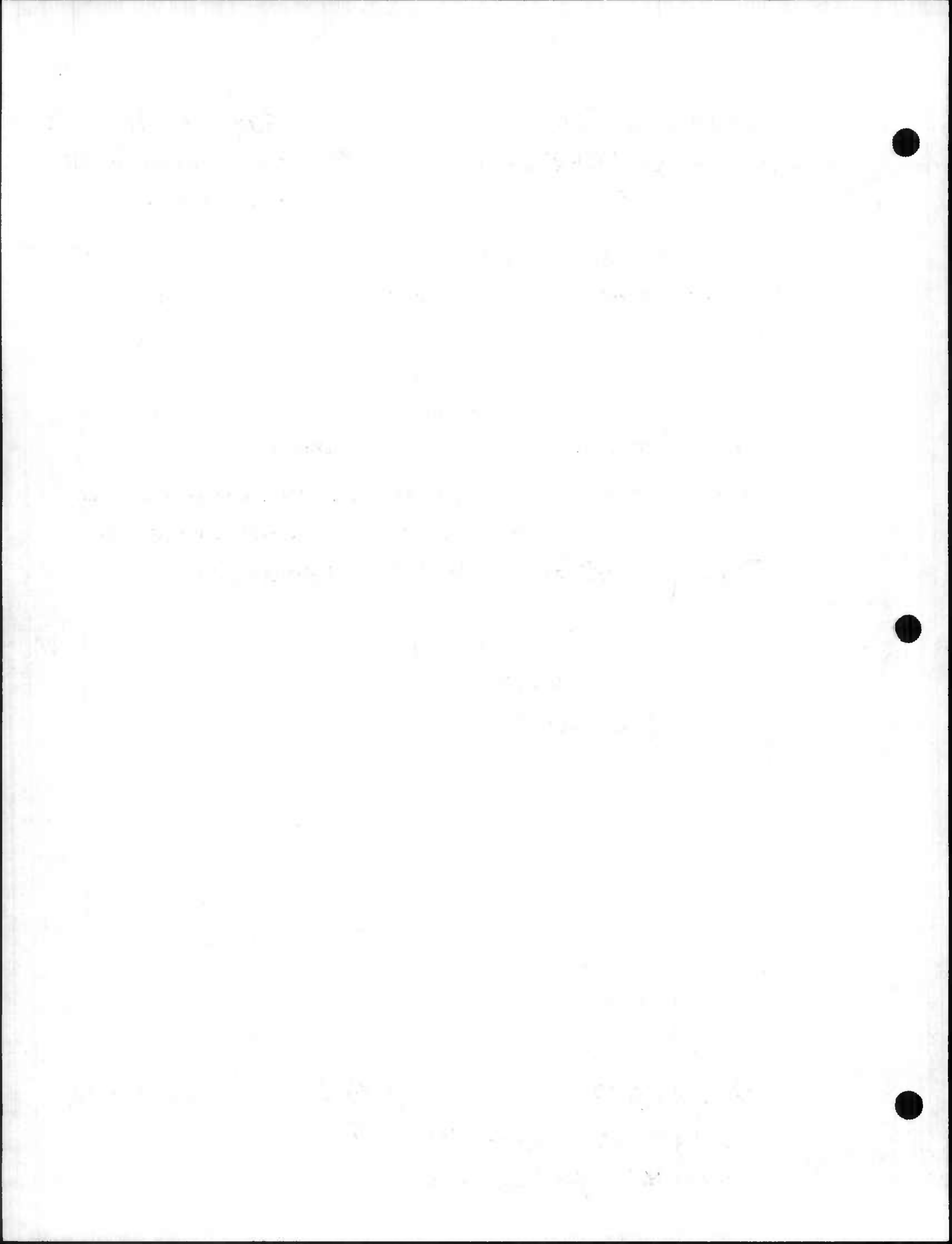
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25241

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Emma

Braverman

2. Date of Death

Month

Day

Year

Aug

9

1997

3. Time of Death

2:35

P.m.

4a. Facility Name (If not institution, give street and number)

St. Agnes Memorial Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral
Director

5. Social Security Number

216-12-6437

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

82

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Dec 30 1915

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Pasadena

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

939 Mount Desert Harbor

10f. Zip Code

21122

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Dress Maker

16b. Kind of Business/Industry

Clothing/Retail

17. Father's Name (First, Middle, Last)

Fred T. Gillman

18. Mother's Name (First, Middle, Maiden Surname)

Jennie M. (Unknown)

19a. Informant's Name/Relationship (Type, Print)

Glen M. Morgan (Grandson)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

939 Mount Desert Harbor Pasadena, Maryland 21122

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Asbury United Meth Ch Cem 8/13/97 Arnold, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

John M. Taylor Funeral Home, Inc.

147 Duke of Gloucester St. Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Septic shock

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 week.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CRF, CAD.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

M.D.

29c. License number

PD 9885

29d. Date signed (Month, Day, Year)

Aug, 9, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hartham Bishara St Agnes Hospital 900 Caton Ave. Baltimore, MD 21229

31. Date filed (Month, Day, Year)

AUG 11 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

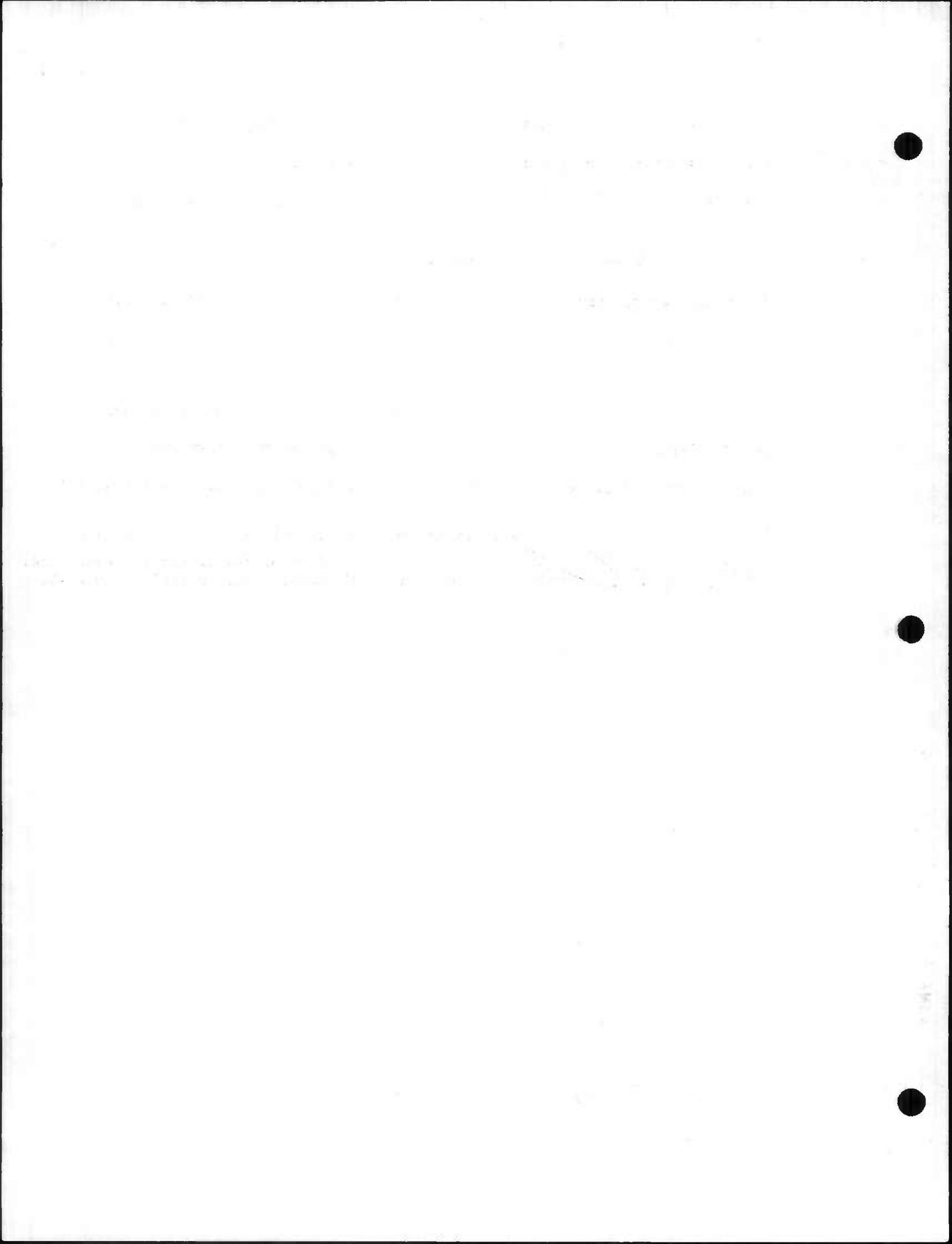
To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

NAME: BRAVERMAN, EMMA

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25242

Certificate of Death

Reg. No.

| | | | | | | | |
|---|---|--|--|--|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) CHARLES E. Brown | | | 2. Date of Death Month August Day 02 Year 97 | | 3. Time of Death 3:00 AM | |
| | 4a. Facility Name (If not institution, give street and number) WASHINGTON ADVENTIST HOSPITAL | | | 4b. City, Town, or Location of Death TAKOMA PARK | | 4c. County of Death MONT | |
| Funeral Director | 5. Social Security Number 579-36-3832 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 67 Yrs. | 8. Date of Birth Month 10 Day 23 Year 29 | | 9. Birthplace (State or Foreign Country) WASHINGTON, DC |
| | Usual Residence of Decedent | | | | | | |
| 10a. State DC | | 10b. County N/A | | 10c. City, Town or Location WASHINGTON | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 407 ONEIDA STREET NE | | | | 10f. Zip Code 20011 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. AFRO-AMERICAN Specify: | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11TH GRADE College (1-4or 5+) NONE | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TRUCK DRIVER | | 16b. Kind of Business/Industry GOVERNMENTAL | |
| 17. Father's Name (First, Middle, Last) HARRY CHASE | | | | 18. Mother's Name (First, Middle, Maiden Surname) BERTHA SHIELDS | | | |
| 19e. Informant's Name/Relationship (Type, Print) ROSE BROWN (WIFE) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS 10A, B, C, D, E, & F | | | |
| 6 | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) HARMONY MEMORIAL PARK | | Date 8/9/97 | | 20c. Location - City or Town, State LANDOVER, MD. |
| | 21. Signature of Funeral Service Licensee <i>Juan Smith</i> | | 22. Name and Address of Facility JOHN T. RHINES CO., INC. 3030 12TH ST NE, DC 20017 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardio-Pulmonary arrest Due to (or as a consequence of): b. Diabetes mellitus Due to (or as a consequence of): c. Hypertension Due to (or as a consequence of): d. End Stage Renal disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| Approximate Interval Between Onset and Death 2 hrs. > years > years one year | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. - Alcohol Abuse - Anemia | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of injury (Month, Day Year) | | 28b. Time of injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. Signature and title of certifier <i>Juan Smith M.D.</i> | | | | 29c. License number D19609 | | 29d. Date signed (Month, Day, Year) 8-2-97 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAMAN R. Tuli 3503 PERRY ST. MT. RAINIER MD 20712 | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 06 1997 | | | | 32. Registrar's Signature <i>John A. Randall</i> | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25243

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John W Bush

2. Date of Death

Month
AugustDay
1Year
1997

3. Time of Death

1:55 AM

4a. Facility Name (If not institution, give street and number)

GOLDEN OAKS NURSING HOME

4b. City, Town, or Location of Death

LAUREL

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

213-38-2059

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

58

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Sept. 10, 1938

9. Birthplace (State or Foreign Country)

Chaptico, MD

Usual Residence of Decedent

10e. State

District of Columbia

10b. County

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

858 20th Street, N. E.

10f. Zip Code

20002

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☒ Yes 2 ☐ No 11/2/61-
If Yes, Give
Year or Dates: 11/1/6313. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

U. S. Postal Employee

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Herman Bush

18. Mother's Name (First, Middle, Maiden Surname)

Louise Baker

19a. Informant's Name/Relationship (Type, Print)

Ann B. Brown - Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1811 8th Street, N.W., Washington, D.C. 20001

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Quantico National Cemetery

Date

8/5/97

20c. Location - City or Town, State

Triangle, VA

21. Signature of Funeral Service Licensee

John T. Stewart III

22. Name and Address of Facility

STEWART FUNERAL HOME, Inc.

4001 Benning Road, N. E., Washington, D.C. 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. END STAGE LIVER FAILURE

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

725.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. CIRRHOSIS

Due to (or as a consequence of):

725

c. ALCOHOL DEPENDENCY

Due to (or as a consequence of):

725

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ANEMIA, HYPERTENSION, COLON CANCER

ASCVD

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
injury

M

28c. Injury et
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Robert Y. Maggin, MD

29c. License number

D25422

29d. Date signed (Month, Day, Year)

August 1, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ROBERT Y. MAGGIN, MD

14333 LAUREL BOWIE RD. #307
LAUREL, MD 20708

31. Date filed (Month, Day, Year)

AUG 04, 1997

32. Registrar's Signature

John Anderson Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25244

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William Brown

2. Date of Death

Month

Day

Year

07

28

97

3. Time of Death

5:15A

4a. Facility Name (If not institution, give street and number)

Manor Care

4b. City, Town, or Location of Death

Wheaton, MD

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

578 42 5509

8. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

64

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

JAN 31, 1933

9. Birthplace (State or Foreign Country)

Wash. D.C.

Usual Residence of Decedent

10a. State

D.C.

10b. County

NONE

10c. City, Town or Location

WASHINGTON, D.C.

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

3915 S STREET S.E.

10f. Zip Code

20020

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

ENVIROMENT TECHNICIAN

16b. Kind of Business/Industry

GOVERNMENT

17. Father's Name (First, Middle, Last)

GEORGE BROWN

18. Mother's Name (First, Middle, Maiden Sumama)

SADIE BANKS

19a. Informant's Name/Relationship (Type, Print)

LAURA SIMMS (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8209 BATHGATE COURT, CLINTON, MD

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

HARMONY MEMORIAL

Date

AUG 1, 1997 LANDOVER, MD

21. Signature of Funeral Service Licensee

Ralph Williams

22. Name and Address of Facility

RALPH WILLIAMS FUNERAL SVC
517 11th STREET S.E.23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. ARRHYTHMIA
Due to (or as a consequence of):Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and DeathFew
minutes.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Metastatic Bladder cancer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accidental 6 ☐ Investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide 6 ☐ determined28a. Date of Injury
(Month, Day Year)28b. Time of
injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

L. Chellani

29c. License number

D42518

29d. Date signed (Month, Day, Year)

JULY 29, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GUL CHABLANI, 11119 ROCKVILLE PIKE #316, ROCKVILLE MD 20852

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

John Davidson Randall

State

Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25245

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|---|--|---|---|---|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Robert James Culley | | | | 2. Date of Death Month Day Year August 5 1997 | | 3. Time of Death 5:15 p.m. | | |
| | 4a. Facility Name (If not institution, give street and number) 234 Crothers Road | | | | 4b. City, Town, or Location of Death Rising Sun | | 4c. County of Death Cecil | | |
| Funeral Director | 5. Social Security Number 420-60-9161 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 51 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) January 15, 1946 | 9. Birthplace (State or Foreign Country) Alabama | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Cecil | | 10c. City, Town or Location Rising Sun | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number 234 Crothers Road | | | | 10f. Zip Code 21911 | | 10g. Citizen of What Country? United States | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4or 5+) 11 | | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) General maintenance worker | | 16b. Kind of Business/Industry Highway Maintenance Shop | | | | |
| | 17. Father's Name (First, Middle, Last) Walter Culley | | | | 18. Mother's Name (First, Middle, Maiden Surname) Willene Paul | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) T. Ann Culley / Spouse | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 234 Crothers Road, Rising Sun, MD 21911 | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) North East Methodist Cem. | | Date Aug. 8 1997 | | 20c. Location - City or Town, State North East, Maryland | | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, MD 21901 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Astrocytoma / Oligodendroglioma</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier  | | 29c. License number D44373 | | 29d. Date signed (Month, Day, Year) 8, 6, 97 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph K. Werdner, Jr., MD 101 Colonial Way, Suite 1 Rising Sun, MD 21911 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 07 1997 | | | | 32. Registrar's Signature  | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25246

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) DONNA JEAN COY | | | | 2. Date of Death Month Day Year August 7, 1997 | | 3. Time of Death 12:05 A.M. | |
| | 4a. Facility Name (If not institution, give street and number) HARFORD MEMORIAL HOSPITAL | | | | 4b. City, Town, or Location of Death HAVRE de GRACE | | 4c. County of Death HARFORD | |
| Funeral Director | 5. Social Security Number 236-52-0757 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 62 Yrs. | | 8. Date of Birth (Month, Day, Year) OCT. 31, 1934 | |
| | 9. Birthplace (State or Foreign Country) WEST VIRGINIA | | 10a. State MARYLAND | | 10b. County CECIL | | 10c. City, Town or Location RISING SUN | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | 10e. Street and Number 112 WOODY BROWN ROAD | | | | 10f. Zip Code 21911 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) House Wife | | 16b. Kind of Business/Industry ----- | | | |
| | 17. Father's Name (First, Middle, Last) WALTER D. OXIER | | | | 18. Mother's Name (First, Middle, Maiden Surname) BROOKIE COOK | | | |
| | 19a. Informant's Name/Relationship (Type, Print) JOHN E. COY HUSBAND | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 112 WOODY BROWN RD. RISING SUN, MD. 21911 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) WEST NOTTINGHAM CEMETERY | | 20c. Location - City or Town, State Rising Sun, Maryland | | 20d. Date 8/11/97 | |
| | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home Perryville, Maryland 21903 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Hepatic failure</i> Due to (or as a consequence of): b. <i>Cirrhosis of liver</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Malignant Lymphoma, small lymphocytic type, Diabetes mellitus, Hypertension, Hypersplenism, Hypertensive arterio-sclerotic cardiovascular disease, spontaneous bacterial peritonitis</i> | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier <i>[Signature]</i> | | | |
| | 29c. License number D15103 | | | | 29d. Date signed (Month, Day, Year) 8/7/97 | | | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) SANG W. KIM, M.D. 3085 Union Ave. Havre de Grace, M.D. 21078 | | | | | | | |
| | 31. Date filed (Month, Day, Year) AUG 08 1997 | | | | 32. Registrar's Signature <i>[Signature]</i> | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25247

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|---|--|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Margaret Beatrice Criddle | | | | 2. Date of Death Month Day Year August 5 1997 | | 3. Time of Death 1947 | | |
| | 4e. Facility Name (If not institution, give street and number) Union Hospital of Cecil County | | | | 4b. City, Town, or Location of Death Elkton | | 4c. County of Death Cecil | | |
| Funeral Director | 5. Social Security Number 235-58-3260 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 75 Yrs. | | 8. Date of Birth (Month, Day, Year) July 7, 1922 | | |
| | 9. Birthplace (State or Foreign Country) West Virginia | | 10e. State Maryland | | 10b. County Cecil | | 10c. City, Town or Location Elkton | | |
| Usual Residence of Decedent | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 8 Apple Lane | | 10f. Zip Code 21921 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (14 or 5+) | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Meat wrapper | | 16b. Kind of Business/Industry Grocery | | | | | |
| 17. Father's Name (First, Middle, Last) Alonzo McKenzie | | | | 18. Mother's Name (First, Middle, Maiden Surname) Myrtle M. Maynard | | | | | |
| 19e. Informant's Name/Relationship (Type, Print) Harold D. Criddle/Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Apple Lane, Elkton, Maryland 21921 | | | | | |
| 20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) North East Methodist Cem. | | Date August 12, 1997 | | 20c. Location - City or Town, State North East, Maryland | | | |
| 21. Signature of Funeral Service Licensee <i>Donald S. Hicks</i> | | | | 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 West Stockton Street, Elkton, MD 21921 | | | | | |
| 23e. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Severe COPD Due to (or as a consequence of): b. CAD Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 20 yrs 1 yr | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | 26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>Jose Ma.</i> | | 29c. License number D44716 | | 29d. Date signed (Month, Day, Year) 8/11/97 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Jose Ma, M.D. 111 West High Street, Elkton, Maryland 21921 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 11 1997 | | | | 32. Registrar's Signature <i>John Davidson</i> | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25248

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Eva Brooks Campbell

2. Date of Death

Month Day Year
July 25, 1997

3. Time of Death

10:30 AM

4a. Facility Name (If not Institution, give street and number)

6210 41st Avenue

4b. City, Town, or Location of Death

Hyattsville

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

454-88-1635

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

100

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Jan. 24, 1897

9. Birthplace (State or Foreign Country)

Texas

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

6210 41st Avenue

10f. Zip Code

20782

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Robert M. Brooks

18. Mother's Name (First, Middle, Maiden Surname)

Julia E. Hand

19a. Informant's Name/Relationship (Type, Print)

H. C. Campbell, Jr. (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3813 Brookvalley Street, Granbury, TX 76048

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Dowell Cemetery

Date

7-29-97

20c. Location - City or Town, State

Dowell Community, Texas

21. Signature of Funeral Service Licensee

Eileen H. Rapp

22. Name and Address of Facility

Rapp Funeral Services, P. A.

933 Gist Avenue, Silver Spring, MD 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Alzheimer's Disease

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dysphagia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Paul A. DeVore, M.D.

29c. License number

D01852

29d. Date signed (Month, Day, Year)

July 25, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Paul A. DeVore, M. D., 4203 Queensbury Road, Hyattsville, MD 20781

31. Date filed (Month, Day, Year)

JUL 28 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25249

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Tsong Mong Chang

2. Date of Death

Month Day Year
July 27, 1997

3. Time of Death

9:52AM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

572-72-1050

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 21, 1911

9. Birthplace (State or Foreign Country)

China

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4426 Renn Street

10f. Zip Code

20853

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Asian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Manager

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Unknown

19a. Informant's Name/Relationship (Type, Print)

Tsu K. Chang

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14103 Arctic Avenue Rockville, Maryland 20853

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

7/28/97

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.
500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. *Acute myocardial infarction*
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?
1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D09834

29d. Date signed (Month, Day, Year)

7/28/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

BARRY ROSENBAUM 3720 FARRAGUT AVE. KENSINGTON, MD 20895

31. Date filed (Month, Day, Year)

JUL 29 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25250

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Stephen Checkon, Jr.

2. Date of Death

Month Day Year
July 26, 1997

3. Time of Death

10:25PM

4a. Facility Name (If not institution, give street and number)

16 Fairwood Court

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

190-26-4016

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

62

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 30, 1935

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

16 Fairwood Court

10f. Zip Code

20850

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: Korean

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Administrator

16b. Kind of Business/Industry

Public Schools

17. Father's Name (First, Middle, Last)

Stephen Checkon, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Pearl Sebastian

19a. Informant's Name/Relationship (Type, Print)

Gerrie Marsar Checkon/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16 Fairwood Court, Rockville, Maryland 20850

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

July 30, 1997

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

Michael P. Kutta

M00348

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Rockville, Inc., 300 W. Montgomery Avenue,
Rockville, Maryland 20850-2805

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Metastatic Gastric Cancer

Approximate Interval Between Onset and Death

16 Months

e. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

George A. Sotos, M.D.

29c. License number

D43083

29d. Date signed (Month, Day, Year)

July 28, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

George A. Sotos, M.D., 9707 Medical Center Drive, #300, Rockville, Maryland 20850

31. Date filed (Month, Day, Year)

JUL 30 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

97 25251

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) NAOMI COHEN | | | | 2. DATE OF DEATH MONTH July DAY 24 YEAR 1997 | | 3. TIME OF DEATH 1:30am M | |
| 4. SOCIAL SECURITY NUMBER 221-07-1065 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 83 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Jan. 5, 1914 | |
| 8. BIRTHPLACE (State or Foreign Country) Pennsylvania | | | | 9a. FACILITY NAME (If not institution, give street and number) Hebrew Home of Greater Washington | | 9b. CITY, TOWN OR LOCATION OF DEATH Rockville | |
| 9c. COUNTY OF DEATH Montgomery | | | | 10a. STATE Maryland | | 10b. COUNTY Montgomery | |
| 10c. CITY, TOWN OR LOCATION Rockville | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 2289 Glenmore Terrace | |
| 10f. ZIP CODE 20850 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Salesperson | | 16b. KIND OF BUSINESS/INDUSTRY Department Store | |
| 17. FATHER'S NAME (First, Middle, Last) Samuel Simon | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Molly Sadoff | | | |
| 19a. INFORMANT'S NAME (Type/Print) Elaine Amir/Daughter | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2289 Glenmore Terrace Rockville, MD 20850 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Judean Mem. Gardens 7/25/97 Olney, MD | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Peter L. House | | | | 22. NAME AND ADDRESS OF FACILITY Ives-Pearson Funeral Homes 22046 472 N. Washington St. Falls Church, VA | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → AMYOTROPHIC LATERAL SCLEROSIS DUE TO (OR AS A CONSEQUENCE OF): a. b. c. d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Michael Senior Staff Physician | | | | 29c. LICENSE NUMBER D18084 | | 29d. DATE SIGNED (Month, Day, Year) JULY 24, 1997 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) D. D. PATEL, M.D. 6121 MONTROSE RD, ROCKVILLE, MD 20852 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 28 1997 | | | | 32. REGISTRAR'S SIGNATURE J. Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

State of Maryland / Department of Health and Mental Hygiene **97 25252**
Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)

Elaine Cokinos

2. Date of Death

Month Day Year

July 27, 1997

3. Time of Death

1:45 P.M.

4a. Facility Name (If not institution, give street and number)

10813 ADMIRALS WAY

4b. City, Town, or Location of Death

POTOMAC

4c. County of Death

MONTGOMERY

5. Social Security Number

578-20-2653

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

Yrs. 75

8. Date of Birth (Month, Day, Year)

MARCH 19, 1922

9. Birthplace (State or Foreign Country)

SHREVEPORT, LA

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

POTOMAC

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

10813 ADMIRALS WAY

10f. Zip Code

20854

10g. Citizen of What Country?

MONTGOMERY

11. Marital Status

1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) +2 College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOME MAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

HARRISON HUDSON

18. Mother's Name (First, Middle, Maiden Surname)

ALENE FREEMAN

19a. Informant's Name/Relationship (Type, Print)

NICHOLAS COKINOS HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10813 ADMIRALS WAY, POTOMAC, MD 20854

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MOUNT COMFORT CREMATORY

Date

7/29/97

20c. Location - City or Town, State

ALEXANDRIA, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Joseph Gawler's Sons, Inc. 5130 WI AVE NW WDC 20016

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

CARDIAC ARREST, ACUTE

Due to (or as a consequence of):

ARTERIOLOSCLEROSIS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PARKINSON'S DISEASE

OSTEOARTHRITIS

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

DO4686

29d. Date signed (Month, Day, Year)

JULY 29, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT F. DYER, M.D. 5530 WI AVENUE, CHEVY CHASE, MD 20815

31. Date filed (Month, Day, Year)

JUL 30 1997

32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25253

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Charlotte Virginia Collins

2. Date of Death

Month

Day

Year

July 30, 1997

3. Time of Death

11:05 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

229-09-0695

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

July 1, 1915

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

101 Odendhal Avenue, # 906

10f. Zip Code

20877

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cafeteria Worker

16b. Kind of Business/Industry

Food Service

17. Father's Name (First, Middle, Last)

Carlos Collins

18. Mother's Name (First, Middle, Maiden Surname)

Nellie Bly

19a. Informant's Name/Relationship (Type, Print)

Geneva Kelley/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

522 Woodston Road, Rockville, Maryland 20850

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parklawn Memorial Park

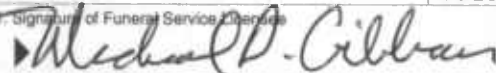
Date

8/4/97

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Provider



22. Name and Address of Facility

DeVol Funeral Home

10 East Deer Park Dr., Gaithersburg, MD. 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Sepsis Syndrome

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 day

b. Fractured Right Hip

Due to (or as a consequence of):

1 week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Rheumatoid Lung Disease, Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural5 ☐ Pending investigation2 ☒ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

July 25, 1997

28b. Time of injury

11:00 P.M.

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Fell in residence

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

At Home

28f. Location (Street and Number or Rural Route Number, City or Town, State)

101 Odendhal Ave.

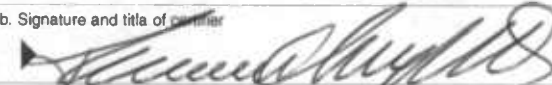
Gaithersburg, MD.

29a. Certifier (Check only one)

1 ☐ Certifying Physician2 ☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

D07099

29d. Date signed (Month, Day, Year)

July 31, 1997

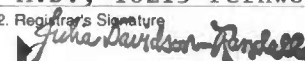
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Francis C. Mayle, Jr., M.D., 10215 Fernwood Road, #301, Bethesda, MD. 20817-1106

31. Date filed (Month, Day, Year)

Aug 01 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25254

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|--|----------------------------------|---|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>Dorothy M Collins</i> | | | | | 2. Date of Death Month <i>July</i> Day <i>25</i> Year <i>1997</i> | | 3. Time of Death <i>11.58 AM</i> | |
| | 4a. Facility Name (If not institution, give street and number) <i>Suburban Hospital</i> | | | | | 4b. City, Town, or Location of Death <i>Bethesda</i> | | 4c. County of Death <i>Montgomery</i> | |
| Funeral Director | 5. Social Security Number <i>577-26-0847</i> | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) <i>75</i> Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) <i>Aug. 23, 1921</i> | | 9. Birthplace (State or Foreign Country) <i>Washington, DC</i> |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State <i>Maryland</i> | | 10b. County <i>Montgomery</i> | | 10c. City, Town or Location <i>Bethesda</i> | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number <i>5015 Battery Lane, #408</i> | | | | | 10f. Zip Code <i>20814</i> | | 10g. Citizen of What Country? <i>United States</i> | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: <i>White</i> | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Data Processor</i> | | | 16b. Kind of Business/Industry <i>Computer</i> | | |
| 17. Father's Name (First, Middle, Last) <i>Everett R. Brown</i> | | | | | 18. Mother's Name (First, Middle, Maiden Surname) <i>Eillen Money</i> | | | | |
| 19a. Informant's Name/Relationship (Type, Print) <i>Rose Marie Stallone</i> | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4740 Bradley Blvd., #318, Chevy Chase, MD 20815</i> | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Chesapeake Crematory</i> | | Date <i>7-26-97</i> | | 20c. Location - City or Town, State <i>Beltsville, Maryland</i> | |
| 21. Signature of Funeral Service Licensee <i>Eileen H. Rapp</i> | | | | | 22. Name and Address of Facility <i>Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910</i> | | | | |
| 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death) | | | | | | | | | <i>Ca Hx</i> |
| Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | <i>24 Hx</i> |
| e. <i>Respiratory Failure</i> Due to (or as a consequence of): | | | | | | | | | |
| b. <i>pneumonia</i> Due to (or as a consequence of): | | | | | | | | | |
| c. <i>Kyphoscoliosis @ COPD</i> Due to (or as a consequence of): | | | | | | | | | |
| d. | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Lymphoma</i> | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | |
| | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier <i>[Signature]</i> | | | 29c. License number <i>D32610</i> | | 29d. Date signed (Month, Day, Year) <i>7-25-97</i> | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>T. J. McNAMARA MD 5602 Shields Drive, Bethesda, Maryland 20817</i> | | | | | | | | | |
| 31. Date filed (Month, Day, Year) <i>JUL 28 1997</i> | | | 32. Registrar's Signature <i>Julia Davidson-Randall</i> | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Collins Dorothy 7/25/97 11:58 AM
Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25255

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CHARLOTTE H. COPELAND

2. Date of Death

Month JULY Day 29, Year 1997

3. Time of Death

12:40 P

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

144-22-4282

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

70

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 7, 1927

9. Birthplace (State or Foreign Country)

Penn.

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

116 North Street

10f. Zip Code

20850

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Sales Associate

16b. Kind of Business/Industry

Dept. Store

17. Father's Name (First, Middle, Last)

William A. Holston

18. Mother's Name (First, Middle, Maiden Surname)

Lacie L. Rawls

19a. Informant's Name/Relationship (Type, Print)

Samuel W. Copeland (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

116 North St., Rockville, MD 20850

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Parklawn Mem. Park

Date

8/2/97

20c. Location - City or Town, State

Rockville, MD

21. Signature of Funeral Service Licensee

George A. Sotos

22. Name and Address of Facility

SNOWDEN FUNERAL HOME, P.A.
ROCKVILLE, MD 2085023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)e. perforated intestine
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

24 hours

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

metastatic colon cancer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury et
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

George A. Sotos, M.D.

29c. License number

D43083

29d. Date signed (Month, Day, Year)

July 29, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

George A. Sotos, M.D. 9707 Medical Center Dr., Rockville, MD 20850

31. Date filed (Month, Day, Year)

JUL 31 1997

32. Registrar's Signature

*John Davidson-Randall*State
Registrar

Baltimore, Maryland 21215-0020

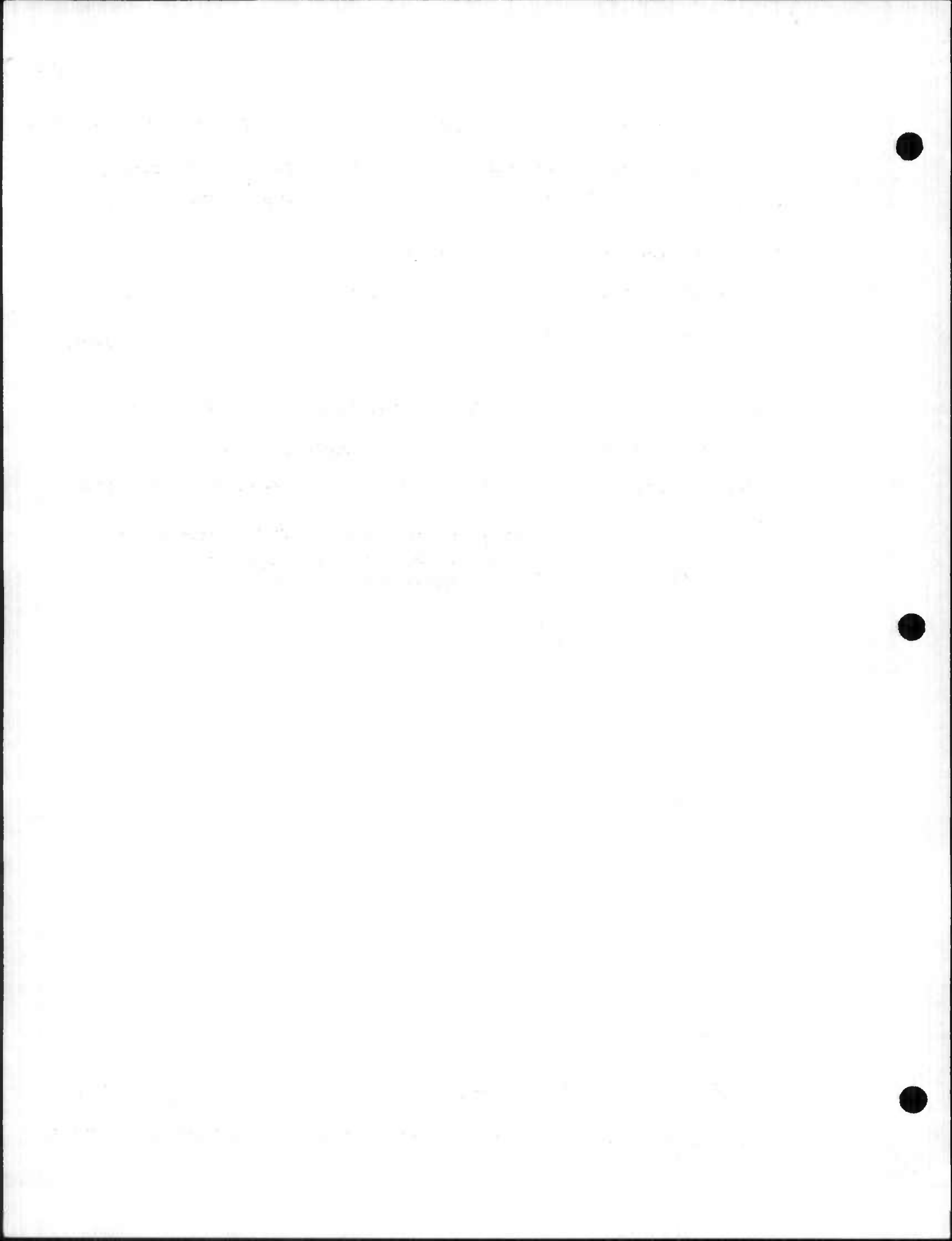
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

12



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25256

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Anna Louise Ball Williamson Curry

2. Date of Death

Month Day Year
July 27, 1997

3. Time of Death

6:30 AM

4a. Facility Name (If not institution, give street and number)

Spa Creek Center, Genesis Elder Care

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

577-24-4766

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

93

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 6, 1904

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

West River

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

4931 East Chalkpoint Road

10f. Zip Code

20778

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Registered Nurse

16b. Kind of Business/Industry

Nursing

17. Father's Name (First, Middle, Last)

Stephen Matthew Ball

18. Mother's Name (First, Middle, Maiden Surname)

Sara Louise White

19a. Informant's Name/Relationship (Type, Print)

Hal Whitney Williamson / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4931 East Chalkpoint Road, West River, MD 20778

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Montgomery Crematorium, Inc.

Date

July 28, 1997

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

Michelle J. Kotta

M00348

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/
Rockville, Inc., 300 W. Montgomery Avenue,
Rockville, Maryland 20850-2805

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration Pneumonia

Due to (or as a consequence of):

1 week

b. Chronic Tube Feeding

Due to (or as a consequence of):

6 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

Osteoporosis with severe chronic pain

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

26. Place of Death (Check only one)

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only)

☒ Medical Examiner

1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Peter F. Verkouw, MD

29c. License number

D11653

29d. Date signed (Month, Day, Year)

July 28, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Peter F. Verkouw, M.D., 2003 Medical Parkway, Suite 100, Annapolis, MD 21401

31. Date filed (Month, Day, Year)

JUL 30 1997

32. Registrar's Signature

*John Davidson-Randall*State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25257

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Paul

Clayton

Henninger

2. Date of Death

Month
JulyDay
30,Year
1997

3. Time of Death

5:12A.

4a. Facility Name (If not institution, give street and number)

11708 Emack Road

4b. City, Town, or Location of Death

Beltsville

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

178-05-5875

6. Sex

XX M 2 F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 2, 1919

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10e. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Beltsville

10d. Inside City Limits

1 Yes XX No

10e. Street and Number

11708 Emack Road

10f. Zip Code

20705

10g. Citizen of What Country?

United States

11. Marital Status

1 Never Married 2 XX Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 Yes XX No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes XX No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12College (1-4 or 5+)
416a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Telephone Central Office Repair

16b. Kind of Business/Industry

C & P Telephone Co.

17. Father's Name (First, Middle, Last)

Noble R. Henninger

18. Mother's Name (First, Middle, Maiden Surname)

Margie Louise Lauer

19a. Informant's Name/Relationship (Type, Print)

Marian Yost Henninger (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

same as #10

20a. Method of Disposition

XX Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Fort Lincoln Cemetery 8/1/1997

Date

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

Donald V. Borgwardt

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, P.A.
4400 Powder Mill Rd. Beltsville, Maryland 2070523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. CARDIOGENIC SHOCK
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

2 days

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. SEVERE CONGESTIVE CARDIOMYOPATHY
Due to (or as a consequence of):

7-6 months

c. ISCHEMIC HEART DISEASE
Due to (or as a consequence of):

16 yrs

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 XX No 3 Probably 4 Unknown

24a. Was an autopsy
performed?

1 Yes XX No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1 Yes XX No

25. Was case referred to medical
examiner?

1 Yes 2 XX No

28. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home XX Residence 6 Other (Specify)

27. Manner of Death

XX Natural 5 Pending
2 Accident investigation
3 Suicide 6 Could not be
4 Homicide determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 Yes XX No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Christine De Lima MD

29c. License number

D 22755

29d. Date signed (Month, Day, Year)

July 30, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Christine De Lima, M.D. 7350 Van Dusen Rd. Laurel, Maryland 20707 (#260)

31. Date filed (Month, Day, Year)

JUL 31 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10

1. The first part of the paper is devoted to the study of the properties of the function $f(x)$ defined by the equation $f(x) = \int_0^x f(t) dt$. It is shown that $f(x)$ is a constant function, and its value is determined by the initial condition $f(0) = 1$.

2. In the second part, we consider the problem of finding the maximum value of the function $f(x)$ on the interval $[0, 1]$. It is shown that the maximum value is attained at $x = 0$ and is equal to 1.

3. The third part of the paper is devoted to the study of the properties of the function $f(x)$ defined by the equation $f(x) = \int_0^x f(t) dt$. It is shown that $f(x)$ is a constant function, and its value is determined by the initial condition $f(0) = 1$.

4. In the fourth part, we consider the problem of finding the maximum value of the function $f(x)$ on the interval $[0, 1]$. It is shown that the maximum value is attained at $x = 0$ and is equal to 1.

5. The fifth part of the paper is devoted to the study of the properties of the function $f(x)$ defined by the equation $f(x) = \int_0^x f(t) dt$. It is shown that $f(x)$ is a constant function, and its value is determined by the initial condition $f(0) = 1$.

6. In the sixth part, we consider the problem of finding the maximum value of the function $f(x)$ on the interval $[0, 1]$. It is shown that the maximum value is attained at $x = 0$ and is equal to 1.

7. The seventh part of the paper is devoted to the study of the properties of the function $f(x)$ defined by the equation $f(x) = \int_0^x f(t) dt$. It is shown that $f(x)$ is a constant function, and its value is determined by the initial condition $f(0) = 1$.

8. In the eighth part, we consider the problem of finding the maximum value of the function $f(x)$ on the interval $[0, 1]$. It is shown that the maximum value is attained at $x = 0$ and is equal to 1.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25258

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JEANNE L.

COLP

2. Date of Death

Month Day Year
JULY 30, 1997

3. Time of Death

18:02 PM

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

Funeral
Director

5. Social Security Number

492-32-4066

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

66

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec 9, 1930

9. Birthplace (State or Foreign Country)

Minnesota

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13 Cool Pond Court

10f. Zip Code

21227

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Certified Nursing Assistant

16b. Kind of Business/Industry

Medical Field

17. Father's Name (First, Middle, Last)

Wyllis Gould Hooper

18. Mother's Name (First, Middle, Maiden Surname)

Rose Kirschhoff

19a. Informant's Name/Relationship (Type, Print)

Kim Belcastro/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

210 Armstrong Lane Pasadena, MD 21122

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lakemont Cemetery

Date

Aug 4
1997

20c. Location - City or Town, State

Davidsonville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Barranco & Sons, P.A. Severna Park Funeral Home
495 Gov. Ritchie Hwy., Severna Park, MD 21146

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

SEPSIS

Due to (or as a consequence of):

two weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

RENAL FAILURE

Due to (or as a consequence of):

two months

CORONARY ARTERY DISEASE

Due to (or as a consequence of):

five years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

M.D.

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

JULY 30, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KARI ROBERTS, M.D., TOWER 110, JOHNS HOPKINS HOSPITAL, BALTIMORE, MARYLAND

31. Date filed (Month, Day, Year)

AUG 05 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

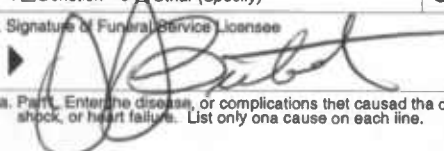
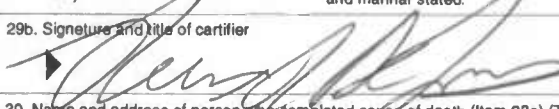
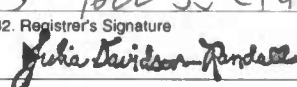
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25259

Certificate of Death

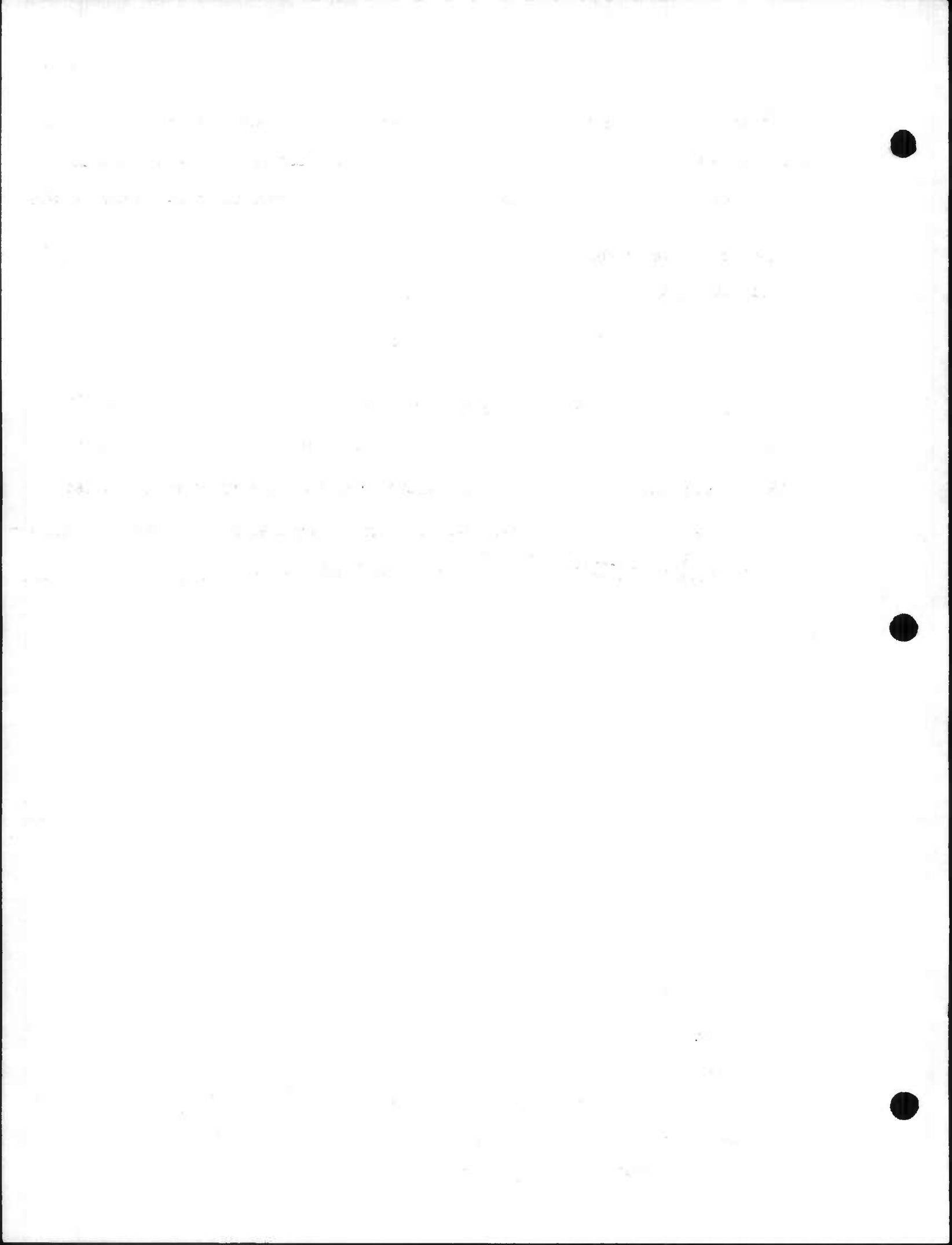
Reg. No.

| | | | | | | | | |
|---|--|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JAMES NELSON COBB | | | 2. Date of Death Month AUGUST Day 6 , Year 1997 | | 3. Time of Death 12:50 AM | | |
| | 4a. Facility Name (If not institution, give street and number) 723 BAYLOR ROAD | | | 4b. City, Town, or Location of Death GLEN BURNIE | | 4c. County of Death ANNE ARUNDEL | | |
| Funeral Director | 5. Social Security Number 233-54-4468 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 62 Yrs. | | 8. Date of Birth (Month, Day, Year) NOV. 22, 1934 | |
| | 9. Birthplace (State or Foreign Country) WEST VIRGINIA | | 10a. State MARYLAND | | 10b. County ANNE ARUNDEL | | 10c. City, Town or Location GLEN BURNIE | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 723 BAYLOR ROAD | | 10f. Zip Code 21061 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1953-1957 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 3 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) FIELD ENGINEER | | 16b. Kind of Business/Industry GENERAL ELECTRIC | | | |
| | 17. Father's Name (First, Middle, Last) RUFUS COBB | | | 18. Mother's Name (First, Middle, Maiden Surname) ELFREIDA MASSIE | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) SANDRA LOU COBB | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 723 BAYLOR ROAD, GLEN BURNIE, MARYLAND 21061 | | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) CHESAPEAKE CREMATORY, INC | | Date 8/6/1997 | | 20c. Location - City or Town, State BELTSVILLE, MARYLAND | |
| | 21. Signature of Funeral Service Licensee  | | | 22. Name and Address of Facility SINGLETON FUNERAL HOME 1 SECOND AVE. S.W., GLEN BURNIE, MARYLAND 21061 | | | | |
| | 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Lung Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | Approximate Interval Between Onset and Death 2 mos | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebrovascular Disease | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | |
| | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. Signature and title of certifier  | | | 29c. License number 031551 | | 29d. Date signed (Month, Day, Year) August 6, 1997 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Russell A. Delmore 1600 S. Cran Highway, Suite 602, Glen Burnie, Md. 21061 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 08 1997 | | 32. Registrar's Signature  | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25260

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Melvin Ralph Cordway

2. Date of Death

Month Day Year
August 5 1997

3. Time of Death

9:12 AM

4a. Facility Name (If not institution, give street and number)

Doctor's Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

572-32-4719

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

65

Yrs.

If Under 1 Year
Months DaysIf Under 24 Hrs.
Hours Min.8. Date of Birth
(Month, Day, Year)

Sept. 2, 1931

9. Birthplace (State or Foreign
Country)

California

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4107 Decatur Street

10f. Zip Code

20781-2126

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1952-195413. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Painter

16b. Kind of Business/Industry

Hotel

17. Father's Name (First, Middle, Last)

(Unknown)

18. Mother's Name (First, Middle, Maiden Surname)

(Unknown)

19a. Informant's Name/Relationship (Type, Print)

Anne Cordway - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4107 Decatur Street, Hyattsville, Maryland 20781

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

MD Veteran's Cemetery

Date

08/11/97

20c. Location - City or Town, State

Cheltenham, Maryland

21. Signature of Funeral Service Licensee

► Claudette A. Doach

22. Name and Address of Facility

Francis Gasch's Sons Funeral Home, P.A.

4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Cardiac-respiratory failure
Due to (or as a consequence of):

days.

b. Advanced metastatic disease
Due to (or as a consequence of):

2 years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Lastc. Bronchogenic Carcinoma
Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

► Bahram Erfan m

29c. License number

D02236

29d. Date signed (Month, Day, Year)

8-5-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BAHRAM ERFAN, MD 6510 KENILWORTH AVE, #2500, RIVERDALE, MD 20737

31. Date filed (Month, Day, Year)

AUG 07 1997

32. Registrar's Signature

John A. Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit10
A

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25261

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Willie James Cole | | | | 2. Date of Death Month Day Year Aug. 4, 1997 | | 3. Time of Death 1:40 A.M. | |
| | 4e. Facility Name (If not institution, give street and number) 8610 Ritchie Road | | | | 4b. City, Town, or Location of Death Forestville | | 4c. County of Death Prince George's | |
| Funeral Director | 5. Social Security Number 578-30-1411 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 67 Yrs. | | 8. Date of Birth (Month, Day, Year) 7/17/30 | |
| | 9. Birthplace (State or Foreign Country) York, S.C. | | 10a. State Md. | | 10b. County P.G. | | 10c. City, Town or Location Forestville | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 8610 Ritchie Road | | 10f. Zip Code 20747 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 54-'57 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th | | College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver | | 16b. Kind of Business/Industry Oil Company | |
| | 17. Father's Name (First, Middle, Last) James Cole | | 18. Mother's Name (First, Middle, Maiden Surname) Ruth Osborne | | 19a. Informant's Name/Relationship (Type, Print) Joann L. Cole/Wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as # 10 above | |
| Physician /Medical Examiner | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Olivet Cem. 8/8/97 | | Date 8/8/97 | | 20c. Location - City or Town, State Wash., D.C. | |
| | 21. Signature of Funeral Service Licensee <i>Darryl W. Brato</i> | | 22. Name and Address of Facility H.S. Washington & Sons, Inc. 4925 Burroughs Ave., N.E. | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Lung cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death 2 months | |
| Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Brain metastases | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once. | 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier <i>David J. Perry</i> | | 29c. License number DC-18561 | | 29d. Date signed (Month, Day, Year) 8/14/97 | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) David J. Perry MD 110 Irving Street NW Washington DC 20010 | | | | | | | |
| | 31. Date filed (Month, Day, Year) AUG 07 1997 | | 32. Registrar's Signature <i>John Andrew Randall</i> | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25262

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BETTIE CAMPBELL

2. Date of Death

Month JULY Day 28 Year 1997 8:35 AM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

PRINCE GEORGES HOSPITAL CENTER

4b. City, Town, or Location of Death

CHEVERLY

4c. County of Death

PRINCE GEORGES

5. Social Security Number

238-82-1310

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

48 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

DEC. 29, 1948

9. Birthplace (State or Foreign Country)

NORTH CAROLINA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

PRINCE GEORGES

10c. City, Town or Location

DISTRICT HEIGHTS

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2307 ROSLYN AVENUE

10f. Zip Code

20747

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

PROCUREMENT SPECIALIST

16b. Kind of Business/Industry

U.S. GOVERNMENT

17. Father's Name (First, Middle, Last)

LESTER PITT, SR.

18. Mother's Name (First, Middle, Maiden Surname)

NELLIE JENKINS

19a. Informant's Name/Relationship (Type, Print)

ROY L. CAMPBELL

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2307 ROSLYN AVENUE, DISTRICT HEIGHTS, MD 20747

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

FORT LINCOLN CEMETERY

Date

8/2/97

20c. Location - City or Town, State

BRENTWOOD, MARYLAND

21. Signature of Funeral Service Licensee

Rain Butting

22. Name and Address of Facility

FORT LINCOLN FUNERAL HOME
3401 BLADENSBURG RD., BRENTWOOD, MD 20722

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a.

SEPTICEMIA

Due to (or as a consequence of):

b.

CARDIOMYOPATHY WITH

Due to (or as a consequence of):

c.

CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

d.

Pneumococcal sepsis

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

L. Bahadori

29c. License number

D47928

29d. Date signed (Month, Day, Year)

7/31/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

L. Bahadori

Prince Georges Hospital

Cheverly, MD

31. Date filed (Month, Day, Year)

AUG 04, 1997

32. Registrar's Signature

John Anderson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25263

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ANNETTE CYNTHIA DAVIS | | | | 2. Date of Death Month Day Year Aug 1 1997 | | 3. Time of Death 9:30 pm | |
| | 4a. Facility Name (If not institution, give street and number) Holy Cross Hospital | | | | 4b. City, Town, or Location of Death Silver Spring | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 578-54-4051 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 56 Yrs. | | 8. Date of Birth (Month, Day, Year) April 14, 1941 | |
| | 9. Birthplace (State or Foreign Country) Dist of Columbia | | 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Silver Spring | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 2301 Glenallen Avenue #103 | | 10f. Zip Code 20906 | | 10g. Citizen of What Country? United States of America | |
| | 11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Social Worker | | 16b. Kind of Business/Industry Private | | | |
| | 17. Father's Name (First, Middle, Last) Wardell McMoore | | 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Davis | | 19a. Informant's Name/Relationship (Type, Print) Gene Truesdale, Son | | | |
| Physician /Medical Examiner | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1347 So. Carolina Ave., SE., Washington, D.C. 20003 | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Glenwood Cemetery | | 20c. Location - City or Town, State Washington, D. C. | |
| | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Lawrence W. Plunkett, Inc. Funeral Home 2504 - 28th St., NE., Washington, D.C. 20018-1413 | | | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Hemorrhagic Shock Due to (or as a consequence of): arterial abscess Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last 1.10 (G) | | Approximate Interval Between Onset and Death 1 hr. Weeks | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 1.10 (G) | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury et Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier | | 29c. License number 208546 | | 29d. Date signed (Month, Day, Year) Aug 1 1997 | |
| | 30. Name and address of person who completed causa of death (Item 23e) (Type, Print) John Towner 8208 Wisconsin Ave | | 31. Date filed (Month, Day, Year) AUG 05 1997 | | | | | |
| To Be Completed by Physician/Medical Examiner | 32. Registrar's Signature | | 33. Registrar's Signature | | | | | |
| | 34. Registrar's Signature | | 35. Registrar's Signature | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25264

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Carrie

Coger

2. Date of Death

Day

8/2/97

Year

3. Time of Death

9:32 AM

4a. Facility Name (If not institution, give street and number)

2702 CURRY DRIVE

4b. City, Town, or Location of Death

ADELPHI, MD

4c. County of Death

PG

Funeral
Director

5. Social Security Number

577-01-4042

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

12/27/01

9. Birthplace (State or Foreign Country)

WASHINGTON, DC

Usual Residence of Decedent

10a. State

MD

10b. County

PG

10c. City, Town or Location

ADELPHI

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2702 CURRY DRIVE

10f. Zip Code

20783

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12 YEARS

College (1-4 or 5+)

NONE

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

GOVERNMENT EMPLOYEE

16b. Kind of Business/Industry

GOVERNMENTAL

17. Father's Name (First, Middle, Last)

WILLIAM ROSIER

18. Mother's Name (First, Middle, Maiden Summa)

UNKNOWN

19a. Informant's Name/Relationship (Type, Print)

CHARLES A. STOKES (CARE TAKER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2702 CURRY DRIVE, ADELPHI, MD

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

LINCOLN MEMORIAL

Date

8/6/97

20c. Location - City or Town, State

SUITLAND, MD.

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

JOHN T. RHINES CO., INC.

3030 12TH ST NE, DC 20017

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIO-RESPIRATORY ARREST

Due to (or as a consequence of):

b. DEMENTIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 MINS.

1 YEAR

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

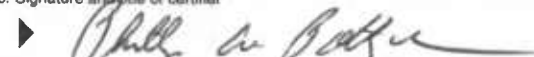
1 ☒

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D 22309

29d. Date signed (Month, Day, Year)

AUGUST 4, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

PHILLIP POTH, PO BOX 3025, SILVER SPRING, MD 20916

State
Registrar

31. Date filed (Month, Day, Year)

AUG 06, 1997

32. Registrar's Signature



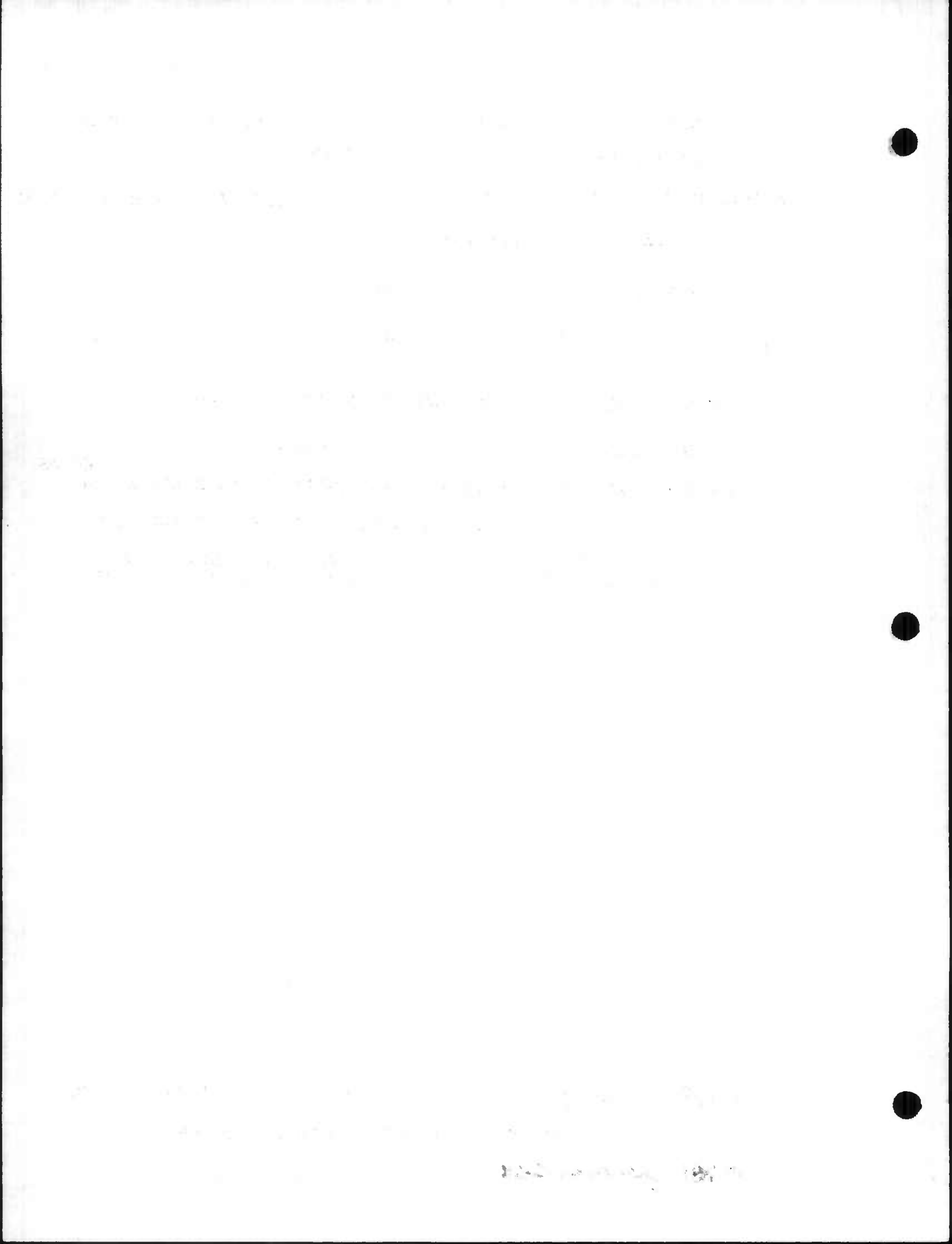
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25265

Certificate of Death

Reg. No.

Amended # 206.P.G.C.8-13-97 CR

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

THOMAS J. CARSWELL, JR.

2. Date of Death

August 3, 1997

3. Time of Death

7:12 PM

4a. Facility Name (If not institution, give street and number)

Prince Georges Medical Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince Georges

Funeral
Director

5. Social Security Number

254-38-7613

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 1, 1930

9. Birthplace (State or Foreign Country)

Georgia

Usual Residence of Decedent

10a. State

Md.

10b. County

Prince Georges

10c. City, Town or Location

Landover

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2011 Kent Village Dr.

10f. Zip Code

20785

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1950-195313. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Letter Carrier

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Thomas J. Carswell, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Susie Mokiver

19a. Informant's Name/Relationship (Type, Print)

Martha Morgan/Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

37 Adams St., N.W., Washington, D.C., 20001

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Cheltenham Nat. Cem. Veteran's

Date

8/12/97

20c. Location - City or Town, State

Cheltenham, Md.

21. Signature of Funeral Service Licensee

Frazier's Funeral Home, Inc.

22. Name and Address of Facility

389 Rhode Av., NW, Washington, D.C. 20001

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Cardiac arrest
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus type 2

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

August 6, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph R. Vaughn, MD, 6492 Landover Rd., Landover, Md.

31. Date filed (Month, Day, Year)

AUG 07 1997

32. Registrar's Signature

John Swisher Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Physician
/Medical
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25266

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ALTHA L. CAMPBELL

2. Date of Death

Aug 4, 1997

3. Time of Death

9:15 PM

4a. Facility Name (If not institution, give street and number)

HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

232-52-9796

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

62

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

FEB 27, 1935

9. Birthplace (State or Foreign Country)

KEYSTONE, W. VA

Usual Residence of Decedent

10a. State
D. C.

10b. County

10c. City, Town or Location

WASHINGTON, D. C.

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1501 CONSTITUTION AVE., N. E.

10f. Zip Code

20002

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12TH GRADE

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

POSTAL SUPERVISOR

16b. Kind of Business/Industry

U S POST OFFICE

17. Father's Name (First, Middle, Last)

CHARLES COBURN

18. Mother's Name (First, Middle, Maiden Surname)

JULIA LIGON

19a. Informant's Name/Relationship (Type, Print)

FREDERICK J. CAMPBELL-HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

192 FLEETWOOD TERR. SILVER SPRING, MD 20910

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

MT. OLIVET CEMETERY

Date

8/11/97 WASH., D. C.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Theodore C. Pinckney

22. Name and Address of Facility

PINCKNEY-SPANGLER FUNERAL HOME

524 - 8TH ST., N. E. WASH., D. C. 20002

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. *Septic shock*

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

4 hrs

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. *left lower lobe infiltrate*

Due to (or as a consequence of):

2 days

c. *post CVA*

Due to (or as a consequence of):

1 month

d. *post craniotomy*

1 week

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*renal failure**Dehydration**Dianhea*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Ellen M. Pinckney MD

29c. License number

D 0051015 MD

29d. Date signed (Month, Day, Year)

Aug 5, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ellen Pinckney 10810 Conn Ave Kensington MD 20895

31. Date filed (Month, Day, Year)

AUG 08 1997

32. Registrar's Signature

*John A. Randall*State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.


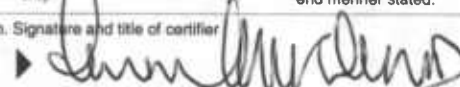
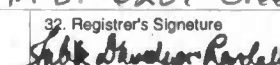
State of Maryland / Department of Health and Mental Hygiene

97 25267

AMENDED # 7.& 8. P.G.C. 8-14-97 cr

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JAMES CARTER | | | | 2. Date of Death Month July Day 23 Year 1997 | | 3. Time of Death 1:20 P.M. | |
| | 4e. Facility Name (If not institution, give street and number) PRINCE GEORGES COMMUNITY HOSPITAL | | | | 4b. City, Town, or Location of Death CHEVERLY, MD | | 4c. County of Death PRINCE GEORGES | |
| Funeral Director | 5. Social Security Number 579 42 8937 | | 6. Sex 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 65 Yrs. | | 8. Date of Birth (Month, Day, Year) MAY 13, 1934 | |
| | 9. Birthplace (State or Foreign Country) WASHINGTON, D.C. | | 10a. State MD | | 10b. County PRINCE GEORGES | | 10c. City, Town or Location LANHAM, MD | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 10e. Street and Number 9927 GOOD LUCK RD. #2 | | 10f. Zip Code 20706 | |
| | 10g. Citizen of What Country? USA | | | | 11. Marital Status 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER | | | | 16b. Kind of Business/Industry LUMBER | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) OLAR CARTER | | | | 18. Mother's Name (First, Middle, Maiden Surname) SYLVIA DAVIS | | | |
| | 19a. Informant's Name/Relationship (Type, Print) RUTH CARTER (WIFE) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 336 16th STREET N.E. Washington, D.C. | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) RIVERDALE CREMATORY | | 20c. Location - City or Town, State JULY 31, 1997 RIVERDALE, MD | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility RALPH WILLIAMS FUNERAL SVC 517 11th STREET S.E. | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) acquired immune deficiency syndrome Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last chronic active hepatitis C, prior AIDS, HIV disease, lymphoma Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. immune system dysfunction, chronic active hepatitis C, prior AIDS, HIV disease, lymphoma | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| | 28c. Injury et Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 28d. Describe how injury occurred | | | |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier  | | | |
| To Be Completed by Physician/Medical Examiner | 29c. License number D01499 | | | | 29d. Date signed (Month, Day, Year) July 23, 1997 | | | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Lewis Dennis, M.D. 6201 Greenbelt Rd., Suite U-1 College Pk. Md. 20740 | | | | 31. Date filed (Month, Day, Year) AUG 14 1997 | | | |
| To Be Completed by Physician/Medical Examiner | 32. Registrar's Signature  | | | | 33. Registrar's Name John Anderson-Randall | | | |
| | 34. Registrar's Title Registrar | | | | 35. Registrar's Address 1000 ... | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25268

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Annie Duval

2. Date of Death

Month

Day

Year

August

04, 1997

3. Time of Death

07:10 AM

Funeral
Director

4e. Facility Name (If not institution, give street and number)

Fallston General Hospital

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

5. Social Security Number

223-30-4468

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

11/3/12

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Tenn

10b. County

Washington

10c. City, Town or Location

Jonesborough

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

125 Sabrina Drive

10f. Zip Code

37659

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Unknown

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Joshua Sage

18. Mother's Name (First, Middle, Maiden Surname)

Sara Ann Pierce

19a. Informant's Name/Relationship (Type, Print)

Michael Reedy - grandson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

125 Sabrina Drive, Jonesborough, TN 37659

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Corinth Cemetery

Date

8/8/97

20c. Location - City or Town, State

Rugby, VA

21. Signature of Funeral Service Licensee

John H. Tillet

22. Name and Address of Facility

Harkins F.H. Inc., Delta, PA 17314

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

SEPSIS

e.

Due to (or as a consequence of):

WOUND INFECTION OF L5 SITE

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

5 days

10 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ACUTE MYOCARDIAL INFARCTION

ACUTE CEREBROVASCULAR ACCIDENT

SEVERE CONGESTIVE HEART FAILURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Attending

29d. Date signed (Month, Day, Year)

D.16444

August 14th 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

VJ Nair, M.D.

31. Date filed (Month, Day, Year)

AUG 6 1997

32. Registrar's Signature

John Andrew Randall

State
Registrar

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25269

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Morris Compton Durham

2. Date of Death

August 6 1997

3. Time of Death

10:20 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

232 Graceford Drive

4b. City, Town, or Location of Death

Aberdeen

4c. County of Death

Harford

5. Social Security Number

461-42-9464

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

12-19-1929

9. Birthplace (State or Foreign Country)

Texas

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Aberdeen

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

232 Graceford Drive

10f. Zip Code

21001

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1951-73

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

United States Army

16b. Kind of Business/Industry

Armed Forces of US

17. Father's Name (First, Middle, Last)

Clarence Sullivan Durham

18. Mother's Name (First, Middle, Maiden Surname)

Nina Florence Faulk

19a. Informant's Name/Relationship (Type, Print)

Mrs. Mary Helen Durham - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

232 Graceford Drive, Aberdeen, MD 21001

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☒ Other (Specify) Entomb.

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Harford Memorial Garden 8/9/97

Date

20c. Location - City or Town, State

Aberdeen, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Mitchell-Smith Funeral Home, P.A.
Havre de Grace, MD 21078-3197

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

Cancer of prostate

Due to (or as a consequence of):

18 MONTHS

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

Huntington's Chorea

Due to (or as a consequence of):

24 yrs

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Louis Silverstein MD

29c. License number

D27154

29d. Date signed (Month, Day, Year)

August 6, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Louis Silverstein, M.D., P. O. Box 8, Havre de Grace, MD 21078 410-939-5843

State

Registrar

31. Date filed (Month, Day, Year)

AUG 7 1997

32. Registrar's Signature

John A. ...

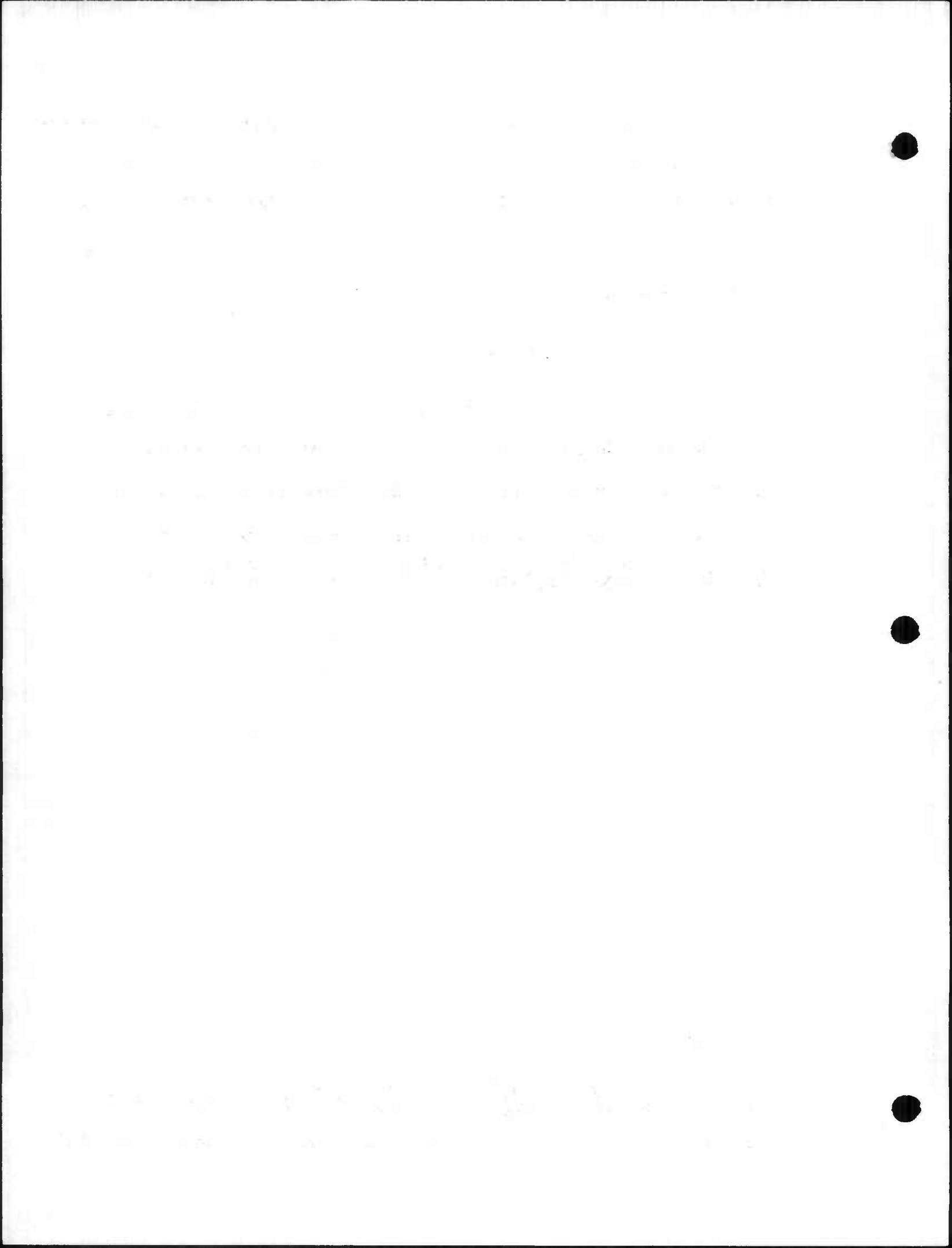
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25270

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lidia

DeBarros

2. Date of Death

Month Day Year
July 30, 1997

3. Time of Death

11:20 AM

4a. Facility Name (If not institution, give street and number)

8501 Carlynn Drive

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

579-62-4786

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

54 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 8, 1943

9. Birthplace (State or Foreign Country)

Brazil

Usual Residence of Decedent

10e. State

Maryland

10b. County

montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8501 Carlynn Drive

10f. Zip Code

20817

10g. Citizen of What Country?

Brazil

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☒ Yes 2 ☐ No Specify:

Brazilian

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Accountant

16b. Kind of Business/Industry

Government of Brazil

17. Father's Name (First, Middle, Last)

Joao Petrovitch

18. Mother's Name (First, Middle, Maiden Surname)

Zina Paskovska

19a. Informant's Name/Relationship (Type, Print)

John DeBarros/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8501 Carlynn Drive Bethesda, Maryland 20817

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parklawn Memorial Park

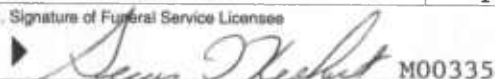
Data

August 1, 1997

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

 M00335

22. Name and Address of Facility

Robert A. Humphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue
Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Cardio Respiratory Arrest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Non Hodgkin Lymphoma

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

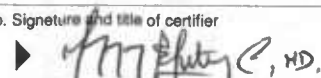
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

 MD.

29c. License number

81522

29d. Date signed (Month, Day, Year)

July 31, 1997

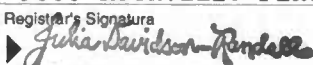
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Martin Guitierrez, M.D. 9000 Rockville Pike Rockville, Maryland 20892

31. Date filed (Month, Day, Year)

AUG 01 1997

32. Registrar's Signature



Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

6

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25271

Certificate of Death

Reg. No.

| | | | | | |
|--|---|--|---|--------------------------------|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Ronald | | 2. Date of Death Month 07 Day 24 Year 97 | | 3. Time of Death 3:50pm |
| | 4a. Facility Name (If not institution, give street and number) Holy Cross Hospital | | 4b. City, Town, or Location of Death Silver Spring | | 4c. County of Death Montgomery |
| Funeral Director | 5. Social Security Number 577-22-0217 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 77 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) Jan. 9, 1920 | | 9. Birthplace (State or Foreign Country) Washington, DC | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County Montgomery | | 10c. City, Town or Location Silver Spring |
| | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| | 10e. Street and Number 607 Sisson Street | | 10f. Zip Code 20902 | | 10g. Citizen of What Country? USA |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: White | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanic-Sheetmetal | | 16b. Kind of Business/Industry Federal Government |
| | 17. Father's Name (First, Middle, Last) Ralph De Simone | | 18. Mother's Name (First, Middle, Maiden Surname) Rosa DiNenna | | |
| | 19a. Informant's Name/Relationship (Type, Print) Rosalie F. De Simone | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 607 Sisson Street, Silver Spring, MD 20902 | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery | | 20c. Location - City or Town, State 7/28/97 Silver Spring, MD |
| | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901 | | |
| Physician /Medical Examiner | 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. | | | | Approximate Interval Between Onset and Death |
| | Immediate Cause (Final disease or condition resulting in death) Metastatic Colon Cancer | | | | 2 yrs |
| | Due to (or as a consequence of): | | | | |
| | Due to (or as a consequence of): | | | | |
| | Due to (or as a consequence of): | | | | |
| | Due to (or as a consequence of): | | | | |
| | Due to (or as a consequence of): | | | | |
| | Due to (or as a consequence of): | | | | |
| | Due to (or as a consequence of): | | | | |
| | Due to (or as a consequence of): | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Iterative Failure Ischemic Heart Disease History of Prostate Cancer | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | | |
| 28a. Date of Injury (Month, Day, Year) | | | | | |
| 28b. Time of Injury M | | | | | |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| 28d. Describe how injury occurred | | | | | |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier | | | | | |
| 29c. License number D29675 | | | | | |
| 29d. Date signed (Month, Day, Year) July 24, 1997 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Ronald V. Boccia, MD 9707 Horizon Center Dr Rockville | | | | | |
| 31. Date filed (Month, Day, Year) JUL 28 1997 | | | | | |
| 32. Registrar's Signature | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25272

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

PETER J. DRIALO SR.

2. Date of Death

Month Day Year
JULY 28, 1997

3. Time of Death

6:20 PM

4a. Facility Name (If not institution, give street and number)

MONTGOMERY GENERAL HOSPITAL

4b. City, Town, or Location of Death

OLNEY

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

155-09-3166

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

97

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JULY 4, 1900

9. Birthplace (State or Foreign Country)

POLAND

Usual Residence of Decedent

10a. State

MD.

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

15300 BEAVERBROOK CT.

10f. Zip Code

20906

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

WHITE

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

POULTRY FARMER

16b. Kind of Business/Industry

POULTRY

17. Father's Name (First, Middle, Last)

STEVEN

DRIALO

18. Mother's Name (First, Middle, Maiden Surname)

KATHERINE

PIASARCZ

19a. Informant's Name/Relationship (Type, Print)

JOSEPH E. DRIALO/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

486 CHURCH ST., ATCO, N.J. 08004

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GATE OF HEAVEN CEMETERY

Date

8/1/97

20c. Location - City or Town, State

BERLIN, N.J.

21. Signature of Funeral Service Licensee

J. W. Chambers

MO0091

22. Name and Address of Facility

CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. septicemia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

chronic renal failure

coronary artery disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

James A. Rossi, M.D.

29c. License number

D24743

29d. Date signed (Month, Day, Year)

JULY 29, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James A. Rossi, M.D. 3305 NORTH LESLIE ROAD BLVD, SILVER SPRING MD 20906

State
Registrar

31. Date filed (Month, Day, Year)

JUL 30 1997

32. Registrar's Signature

Julia Davidson-Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

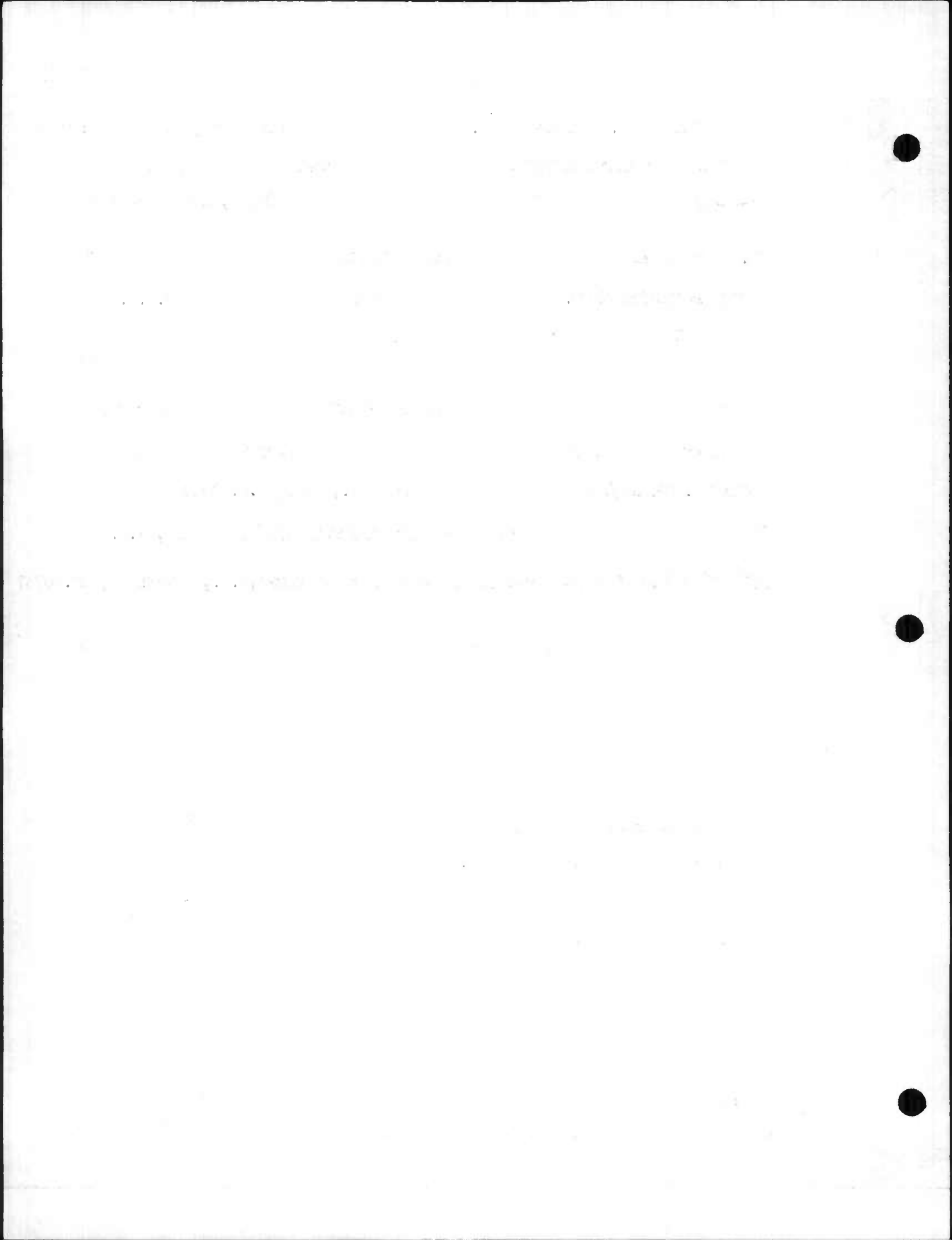
Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 25273**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Stanley D. Dade

2. Date of Death

Month Day Year
August 2 1997

3. Time of Death

11:54 A.M.

4a. Facility Name (If not institution, give street and number)

2104 Glendora Drive

4b. City, Town, or Location of Death

District Heights Prince George's

4c. County of Death

District Heights Prince George's

Funeral
Director

5. Social Security Number

577-50-2290

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

56

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Oct. 20, 1940

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

District Heights

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2104 Glendora Drive

10f. Zip Code

20747

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Automobile Mechanic

16b. Kind of Business/Industry

Automobile Repair

17. Father's Name (First, Middle, Last)

Stanley D. Dade, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Helen Dorsey

19a. Informant's Name/Relationship (Type, Print)

Maitland W. Dade/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2104 Glendora Dr. District Heights, Md. 20747

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metropolitan Crematory

Date

8/3/97

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

George P. Kalas Funeral Home

6160 Oxon Hill Rd. Oxon Hill, Md. 20745

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Non-small cell Lung carcinoma

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

VA 0204048469

29d. Date signed (Month, Day, Year)

August 2, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BASSEMA A. ANTABLI

2150 Pennsylvania Ave. N.W., D.C. 20037

G.W.U. Hospital

State
Registrar

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25274

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|--|---|--------------------------------|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) REBA DALTON | | | | 2. Date of Death Month AUGUST Day 02 Year 1997 | | 3. Time of Death 03:44 PM | |
| | 4a. Facility Name (If not institution, give street and number) LAUREL REGIONAL HOSPITAL | | | | 4b. City, Town, or Location of Death LAUREL | | 4c. County of Death PRINCE GEORGES | |
| Funeral Director | 5. Social Security Number 408-44-5180 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 65 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Oct. 4, 1931 | 9. Birthplace (State or Foreign Country) Maryville, TN |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Prince George's | | 10c. City, Town or Location Laurel | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number 8341 Snowden Oaks Place | | | | 10f. Zip Code 20708 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Printed Circuit Lab Technician NASA | | | | 16b. Kind of Business/Industry | |
| | 17. Father's Name (First, Middle, Last) James Alfred Abbott | | | | 18. Mother's Name (First, Middle, Maiden Surname) Lillie Hazel Teffeteller | | | |
| Physician /Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Thomas M. Dalton - Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8341 Snowden Oaks Place, Laurel, Maryland 20708 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Laws Chapel Cemetery | | Date 8/09/97 | | 20c. Location - City or Town, State Maryville, Tennessee | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, Md. 20781 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ASTHMA MORBID OBESITY | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | |
| | 28a. Date of Injury (Month, Day, Year) | | | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| | 29b. Signature and title of certifier  DME | | | | 29c. License number D 33954 | | 29d. Date signed (Month, Day, Year) AUGUST 03, 1997 | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MARIO F. GOLUE JR MD 3001 HOSPITAL DRIVE, CHEVERLY MARYLAND 20785 | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) AUG 06 1997 | | | | 32. Registrar's Signature  | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 25275**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ELLA L. DINDLEBECK

2. Date of Death
Month Day Year
JULY 28, 1997

3. Time of Death
10:15 A.M.

4a. Facility Name (If not institution, give street and number)

LAUREL REGIONAL HOSPITAL

4b. City, Town, or Location of Death

LAUREL

4c. County of Death

PRINCE GEORGES

Funeral
Director

5. Social Security Number

218-24-0705

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JULY 24, 1905

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

PRINCE GEORGES

10c. City, Town or Location

BELTSVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11608 35TH AVENUE

10f. Zip Code

20705

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWNED HOME

17. Father's Name (First, Middle, Last)

C.L. MARTIN

18. Mother's Name (First, Middle, Maiden Surname)

ROSE LEE KIDWELL

19a. Informant's Name/Relationship (Type, Print)

VIRGINIA LEE CARRO, DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11608 35TH AVENUE, BELTSVILLE, MARYLAND 20705

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

FORT LINCOLN CEMETERY

Date

8/1/97

20c. Location - City or Town, State

BRENTWOOD, MARYLAND

21. Signature of Funeral Service Licensee

Susan S. Johnson

22. Name and Address of Facility

FORT LINCOLN FUNERAL HOME

3401 BLADENSBURG RD., BRENTWOOD, MD

20722

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Cerebrovascular Accident*
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 MONTHS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PNEUMONIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending Investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Andrew Kuntati M.D.

29c. License number

036716

29d. Date signed (Month, Day, Year)

JULY 31, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANDREW KUNTATI M.D. 8317 CHERRY LANE LAUREL, MD 20707

31. Date filed (Month, Day, Year)

AUG 04, 1997

32. Registrar's Signature

John D. Anderson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25276

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Norma W. Esch

2. Date of Death

Month Day Year
July 26, 1997

3. Time of Death

7:35 P.M.

4a. Facility Name (If not institution, give street and number)

Potomac Valley Nursing Home

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

313-18-1836

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

8. Under 1 Year

Months Days

9. Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb. 4, 1922

9. Birthplace (State or Foreign Country)

Indiana

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

☒ Yes ☐ No

10a. Street and Number

1235 Potomac Valley Road

10f. Zip Code

20850

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

William Maynard Wootton

18. Mother's Name (First, Middle, Maiden Surname)

Maude Rayburn

19a. Informant's Name/Relationship (Type, Print)

David W. Esch / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4518 Cheltenham Drive, Bethesda, Maryland 20814

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Montgomery Crematorium, Inc. July 28, 1997

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

Michael P. Kulla M00348

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/

Bethesda-Chevy Chase, Inc., 7557 Wisconsin Ave. Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Stroke

Dementia (multi infarct)

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

26. Place of Death (Check only one)

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Pending investigation☐ Accident☐ Suicide☐ Homicide☐ Could not be determined

28a. Date of injury (Month, Day Year)

28b. Time of injury

M

28c. Injury at work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Paul T. Noone M.D.

29c. License number

D07471

29d. Date signed (Month, Day, Year)

July 28, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul T. Noone, M.D., 50 W. Edmonstone Drive, #207, Rockville, Maryland 20850-1290

31. Date filed (Month, Day, Year)

AUG 01 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25277

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ROSELLA B. ELDRIDGE

2. Date of Death

Month Day Year
AUG. 2 1997

3. Time of Death

6:30 pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

1205 MADISON STREET APT. A 1

4b. City, Town, or Location of Death

ANNAPOLIS

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

213-34-8903

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JULY 16 1932

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

ANNAPOLIS

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1205 MADISON ST. APT. A 1

10f. Zip Code

21403

10g. Citizen of What Country?

US

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOUSEKEEPING

16b. Kind of Business/Industry

WOODWARD & LOTHROP

17. Father's Name (First, Middle, Last)

CHARLES BROWN

18. Mother's Name (First, Middle, Maiden Surname)

LOTTIE TONGUE

19a. Informant's Name/Relationship (Type, Print)

LINDA ELDRIDGE (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

801 B BROOKE COURT ANNAPOLIS, MD. 21401

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ANNAPOLIS MEM. GARDENS

Date

8/7/97

20c. Location - City or Town, State

ANNAPOLIS, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

WM. REESE & SONS MORTUARY, P.A.

821 WEST ST. ANNAPOLIS, MD. 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Acute Myocardial Infarction

Due to (or as a consequence of):

b.

Hypertensive Cardiovascular Disease

Due to (or as a consequence of):

c.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

2 hr

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

① Scleroderma

② Reynold's phenomenon

③ Dysrhythmic Disorder

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D09403

29d. Date signed (Month, Day, Year)

8-5-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ERIN A. Shulman 1833A Rose St. Anne. MD 21401

State
Registrar

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

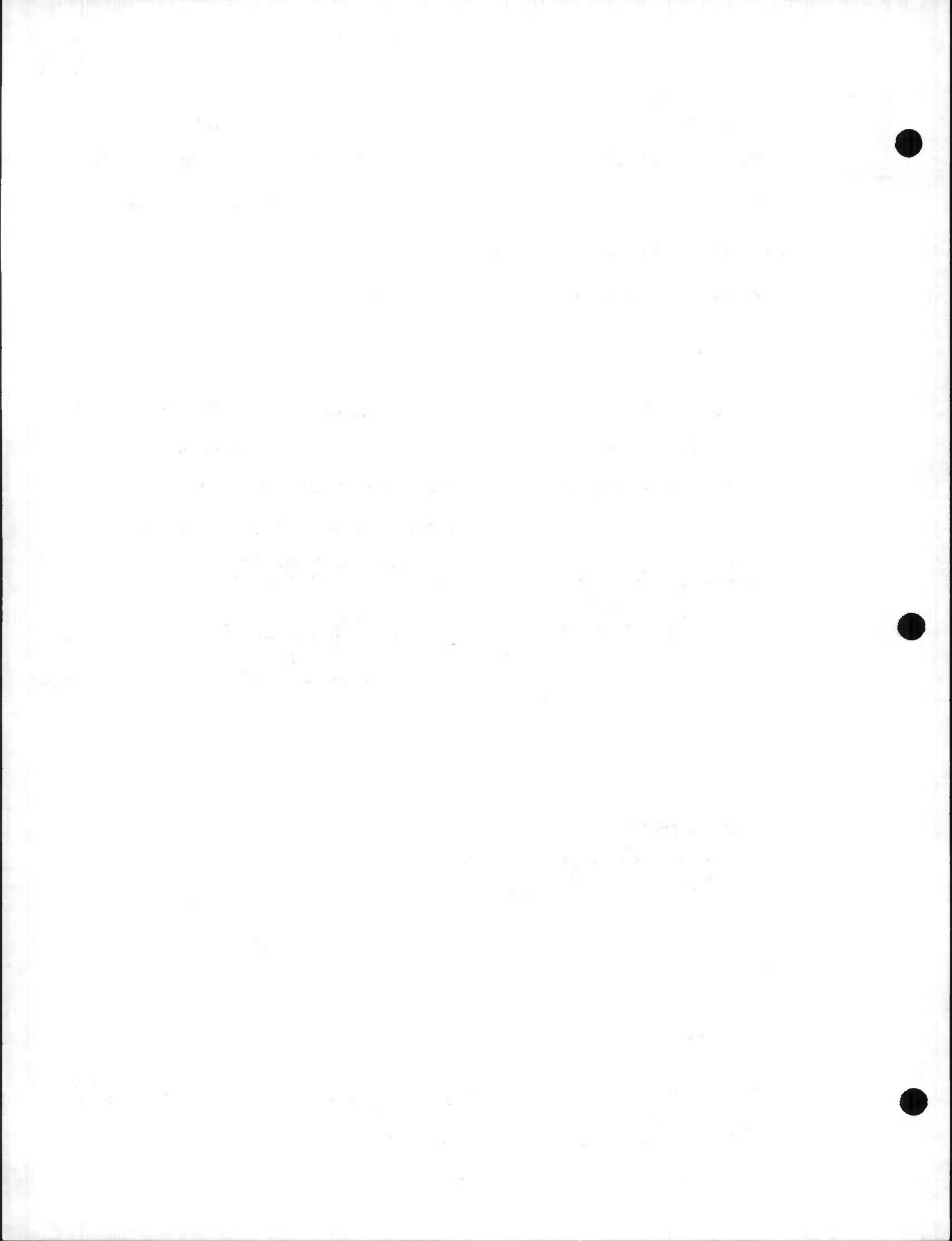
Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended # 17, PG, GC, 8/6/97 State of Maryland / Department of Health and Mental Hygiene 97 25278
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

KIRBY KEITH EDWARDS

2. Date of Death
Month Day Year

07 29 97

3. Time of Death
03:16 AM

4e. Facility Name (If not institution, give street and number)

SOUTHERN MARYLAND HOSPITAL

4b. City, Town, or Location of Death

CLINTON

4c. County of Death

PRINCE GEORGES

Funeral
Director

5. Social Security Number
579-72-0552

6. Sex
1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)
43 Yrs.

If Under 1 Year
Months Days

If Under 24 Hrs.
Hours Min.

8. Date of Birth
(Month, Day, Year)
FEB. 5, 1954

9. Birthplace (State or Foreign
Country)
WASHINGTON, D.C.

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

PRINCE GEORGE'S

10c. City, Town or Location

FT. WASHINGTON

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4115 MARBOURNE DR.

10f. Zip Code

20744

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.
Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: 3/21/72
3/13/75

13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: BLACK

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

CUSTODIAL ENGINEER

16b. Kind of Business/Industry

DOMESTIC

17. Father's Name (First, Middle, Last)

NEOPOLIAN EDWARDS

Nepolian Edwards

18. Mother's Name (First, Middle, Maiden Surname)

ZANA GRISSOM

19a. Informant's Name/Relationship (Type, Print)

LINDA EDWARDS/ WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4115 MARBOURNE DR. FT. WASHINGTON, MARYLAND 20744

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of
cemetery, crematory or other place)

MARYLAND VETERANS CEM.

Date

8/5/97

20c. Location - City or Town, State

CHELTENHAM, MARYLAND

21. Signature of Funeral Service Licensee

Keith A. Savage M1005

22. Name and Address of Facility

ALEXANDER S. POPE FUNERAL HOMES

5538 MARLBORO PIKE/FORESTVILLE, MD. 20747

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

a. ASTHMA

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy
performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical
examiner?
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient

2 ☒ Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury
(Month, Day Year)

28b. Time of
Injury

28c. Injury at
Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

29a. Certifier
(Check only
one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Mario F. Golue Jr. M.D.

29c. License number

DME D 33954

29d. Date signed (Month, Day, Year)

07-29-97

30. Name and address of person who completed cause of death (Item 21e) (Type, Print)

MARIO F. GOLUE JR. MD 3001 HOSPITAL AVE, CHEVERLY MARYLAND 20785

31. Date filed (Month, Day, Year)

AUG 04 1997

32. Registrar's Signature

John A. Wilson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

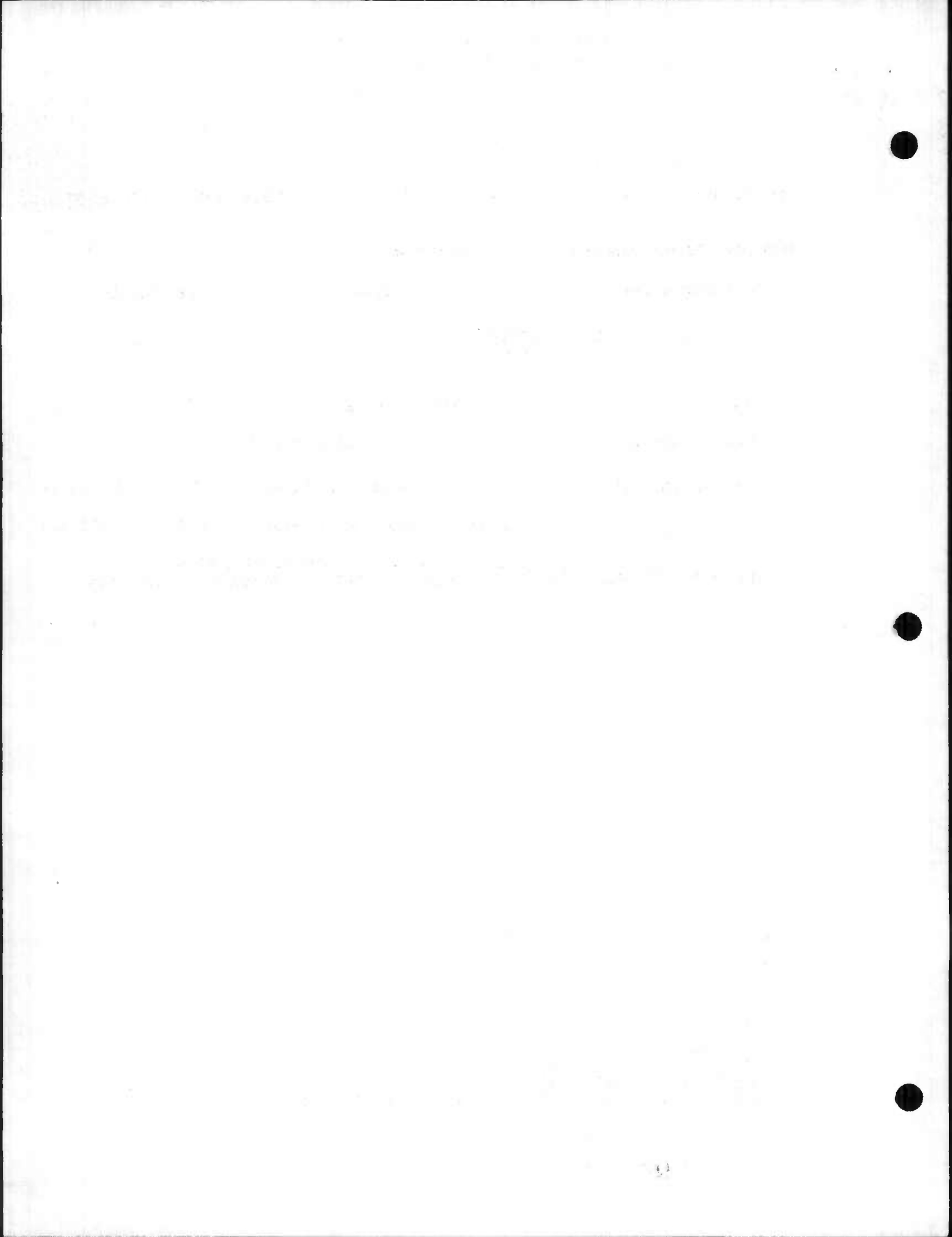
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

7



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 25279

Reg. No.

MARIE A. EVANS

| | | | | | | | | |
|--|--|---|---|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Marie Ann Evans | | | | 2. Date of Death Month Day Year AUGUST 01 1997 | | 3. Time of Death 9:33 PM | |
| | 4a. Facility Name (If not institution, give street and number) DOCTORS HOSPITAL | | | | 4b. City, Town, or Location of Death LANHAM | | 4c. County of Death PRINCE GEORGES | |
| Funeral Director | 5. Social Security Number 219-46-8821 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 52 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) June 20, 1945 | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Prince George's | | 10c. City, Town or Location Lanham | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number 4915 Seltzer Road | | | 10f. Zip Code 20706 | | 10g. Citizen of What Country? U.S.A. | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife | | 16b. Kind of Business/Industry Domestic | | |
| 17. Father's Name (First, Middle, Last) Charles H. Lynn | | | | 18. Mother's Name (First, Middle, Maiden Surname) Dorothy A. Murphy | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mr. Vernon Phillip Evans, Sr. (Husband) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4915 Seltzer Road Lanham, Maryland 20706 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland National Memorial Park | | Date 8/7/97 | | 20c. Location - City or Town, State Laurel, Maryland | | |
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility Rollins Funeral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. 20019 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Pulmonary thrombo-embolism</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Obesity</i> | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier <i>[Signature]</i> | | | | | | |
| | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) AUGUST 02, 1997 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>[Signature]</i> 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date Recd (Month, Day, Year) AUG 08 1997 | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25280
Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|---|--|-------------------------------|--|---|--|---|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) LEO H. FELTY | | | | 2. Date of Death Month July Day 31 Year 1997 | | 3. Time of Death 10:30 AM | | | | |
| | 4a. Facility Name (If not institution, give street and number) Harford Memorial Hospital | | | | 4b. City, Town, or Location of Death Havre de Grace | | 4c. County of Death Harford | | | | |
| Funeral Director | 5. Social Security Number 188-07-5957 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 76 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 7/27/1921 | | 9. Birthplace (State or Foreign Country) Pennsylvania | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State MD | | 10b. County Harford | | 10c. City, Town or Location Street | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 10e. Street and Number 1128 Poplar Grove Road | | | | 10f. Zip Code 21154 | | 10g. Citizen of What Country? United States | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No WW2 & Korea If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Automotive Electronics Instructor | | | 16b. Kind of Business/Industry Civil Service | | | | |
| 17. Father's Name (First, Middle, Last) Frank Felty | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Jenny Adams | | | | | | |
| 19a. Intomment's Name/Relationship (Type, Print) Marie B. Felty/Wife | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1128 Poplar Grove Road, Street, MD 21154 | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Suedberg Church of God Cemetery | | Date 8/4 | | 20c. Location - City or Town, State Suedberg, PA | | | | |
| 21. Signature of Funeral Service Licensee <i>Jeffrey P. Lovelidge</i> | | | | | 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Immediate Cause (Final disease or condition resulting in death) | | | | | | | | | | 1 hour | |
| e. Myocardial Infarction Due to (or as a consequence of): | | | | | | | | | | | |
| b. Coronary Artery disease Due to (or as a consequence of): | | | | | | | | | | 12 years | |
| c. Stroke Due to (or as a consequence of): | | | | | | | | | | 2 years | |
| d. | | | | | | | | | | | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 26a. Date of Injury (Month, Day, Year) | | 26b. Time of Injury M | | 26c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 26d. Describe how injury occurred | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier <i>[Signature]</i> MD | | | 29c. License number D36715 | | 29d. Date signed (Month, Day, Year) Aug. 1, 1997 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Sherif H. Osman, M.D. 39 Churchville Rd. Bel Air, MD 21034 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 4 1997 | | | | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25281

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARIO FUNDORA

2. Date of Death

August 6

Day

Year

1997

3. Time of Death

8:50pm

4a. Facility Name (If not institution, give street and number)

Physicians Memorial Hospital

4b. City, Town, or Location of Death

La Plata

4c. County of Death

Charles

Funeral
Director

5. Social Security Number

125-30-7225

6. Sex

XXM 2□ F

7. Age (In yrs. last birthday)

87

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

FEBRUARY 26, 1910

9. Birthplace (State or Foreign Country)

CUBA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

CHARLES

10c. City, Town or Location

WALDORF

10d. Inside City Limits

1□ Yes 2□ No

10e. Street and Number

3529 NORWOOD COURT

10f. Zip Code

20602

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1□ Never Married 2□ Married
3□ Widowed 4□ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1□ Yes 2□ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1□ Yes 2□ No Specify: CUBAN

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MERCHANT

16b. Kind of Business/Industry

GROCERY STORE/
FOOD

17. Father's Name (First, Middle, Last)

UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname)

ANGELA DUENAS

19a. Informant's Name/Relationship (Type, Print)

MARIA CAMPBELL/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3529 NORWOOD COURT, WALDORF, MARYLAND 20602

20a. Method of Disposition

1□ Burial 2□ Cremation 3□ Removal from State
4□ Donation 5□ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

TRINITY MEMORIAL GARDENS 8/8/1997 WALDORF, MARYLAND

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Director

JPK

MARK G. BROHAWN

M00053

22. Name and Address of Facility

THE HUNTT FUNERAL HOME, INC., POST OFFICE BOX
156, WALDORF, MARYLAND 20604

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE

Due to (or as a consequence of):

b. PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 day
FEW DAYS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RENAL FAILURE

SEIZURE DISORDER

23b. Did tobacco use contribute to the cause of death?

1□ Yes 2□ No 3□ Probably 4□ Unknown

24a. Was an autopsy performed?

1□ Yes 2□ No

24b. Were autopsy findings available prior to completion of cause of death?

1□ Yes 2□ No

25. Was case referred to medical examiner?

1□ Yes 2□ No

Hospital: 1□ Inpatient 2□ ER/Outpatient 3□ DOA

26. Place of Death (Check only one)

Other: 4□ Nursing Home 5□ Residence 6□ Other (Specify)

27. Manner of Death

1□ Natural 2□ Accident 3□ Suicide 4□ Homicide
5□ Pending investigation 6□ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1□ Yes 2□ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1□ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier

J. Brohawn

Attending

29c. License number

D - 44436

29d. Date signed (Month, Day, Year)

Aug 07 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ashvinkumar J. Patel, MD 603 Post Office Road, Suite 207, Waldorf, Maryland 20602

State
Registrar

31. Date filed (Month, Day, Year)

AUG 12 1997

32. Registrar's Signature

John H. Randall

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



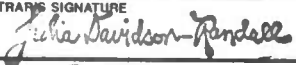
Mario Fundora
Baltimore, Maryland 21215-0020permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

18325 01

97 25282

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|--|--|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) BENJAMIN FAINMAN | | | | 2. DATE OF DEATH MONTH JULY DAY 28, 1997 YEAR | | | | 3. TIME OF DEATH 6:20 a.m. | |
| 4. SOCIAL SECURITY NUMBER 578-18-7918 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 78 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) SEPT. 2, 1918 | | 8. BIRTHPLACE (State or Foreign Country) NY | |
| 9a. FACILITY NAME (If not institution, give street and number) HEBREW HOME OF GREATER WASHINGTON | | | | 9b. CITY, TOWN OR LOCATION OF DEATH ROCKVILLE | | | | 9c. COUNTY OF DEATH MONTGOMERY | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY MONTGOMERY | | 10c. CITY, TOWN OR LOCATION BETHESDA | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 5225 POOKS HILL RD., #401 N. | | | | 10f. ZIP CODE 20814 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1942-45 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ADMINISTRATIVE ASSISTANT | | | 16b. KIND OF BUSINESS/INDUSTRY RETAIL | | |
| 17. FATHER'S NAME (First, Middle, Last) (UNOBTAINABLE) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) REBECCA BECKER | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) BEATRICE E. FAINMAN / WIFE | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5225 POOKS HILL RD., #401 N., BETHESDA, MD 20814 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) JUDEAN MEMORIAL GARD. 7/30/97 | | 20c. LOCATION — City or Town, State OLNEY, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  DANIEL SIMONS | | | | 22. NAME AND ADDRESS OF FACILITY EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CHRONIC RENAL FAILURE DUE TO (OR AS A CONSEQUENCE OF): b. GENERALIZED ARTERIOSCLEROSIS DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death 6 YEARS 20 YEARS | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PERIPHERAL VASCULAR DISEASE | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  MD | | | | 29c. LICENSE NUMBER D 05885 | | 29d. DATE SIGNED (Month, Day, Year) 7/28/97 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) STEVEN LIPSON 6121 MONTROSE RD, ROCKVILLE MD | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JUL 29 1997 | | | | 32. REGISTRAR'S SIGNATURE  | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25283

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|---|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Daisy Watts Fletcher | | | | 2. Date of Death Month Day Year July 24, 1997 | | 3. Time of Death 7:20 PM | |
| | 4e. Facility Name (If not institution, give street and number) Potomac Valley Nursing Home | | | | 4b. City, Town, or Location of Death Rockville | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 212-03-2240 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 91 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Dec. 3, 1905 | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Rockville | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 4816 Creek Shore Drive | | | | 10f. Zip Code 20852 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collage (1-4 or 5+) 12 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Proof Reader | | | 16b. Kind of Business/Industry Insurance | |
| 17. Father's Name (First, Middle, Last) John Thomas Watts | | | | 18. Mother's Name (First, Middle, Maiden Surname) Bertha Albright | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Gloria F. Mock/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4816 Creek Shore Drive, Rockville, Maryland 20852 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Boonsboro Cemetery | | Date July 28, 1997 | | 20c. Location - City or Town, State Boonsboro, Maryland | | |
| 21. Signature of Funeral Service Licensee <i>Michelle P. Kutta</i> M00348 | | | | 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Carcinoma of Bladder Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death 1 Year |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier <i>Myron L. Lenkin, M.D.</i> | | | | 29c. License number 006674 | | 29d. Date signed (Month, Day, Year) 7/28/97 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Myron L. Lenkin, M.D. 2309 Shorefield Road, Wheaton, Maryland 20902-1825 | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 30 1997 | | | | 32. Registrar's Signature <i>Juha Davidson-Rendell</i> | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar

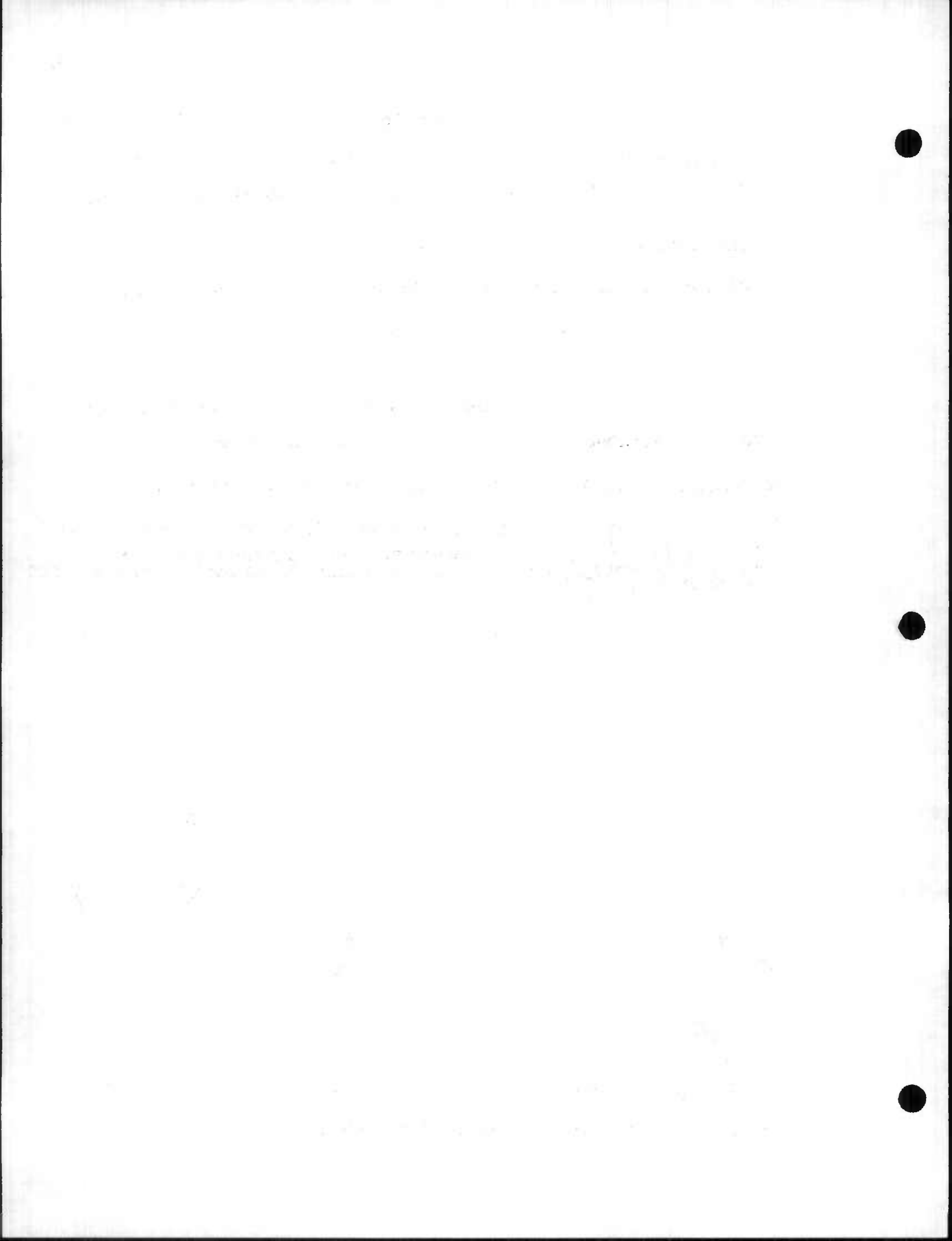
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25284

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Mary E. Fletcher | | | | 2. Date of Death Month July Day 28 Year 1997 | | 3. Time of Death 3:10P. | |
| | 4a. Facility Name (If not institution, give street and number) Hillhaven nursing Home | | | | 4b. City, Town, or Location of Death Adelphi | | 4c. County of Death Prince George's | |
| Funeral Director | 5. Social Security Number 213-26-1063 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 96 Yrs. | | 8. Date of Birth (Month, Day, Year) Nov. 11, 1900 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Randallstown | |
| To Be Completed by Funeral Director | 10e. Street and Number 3542 Carriage Hill Circle, #102 | | 10f. Zip Code 21133 | | 10g. Citizen of What Country? United States | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerical Worker | | 16b. Kind of Business/Industry U.S. Government | | | |
| | 17. Father's Name (First, Middle, Last) Harry E. Fletcher | | | | 18. Mother's Name (First, Middle, Maiden Surname) Kate H. Hartman | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) John Wissman (Nephew) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3860 Irongate Lane Bowie, Maryland 20715 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery | | 20c. Location - City or Town, State Brentwood, Maryland | | 20d. Date 7/30/1997 | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee Donald V. Borgwardt | | | | 22. Name and Address of Facility Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PNEUMONIA Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Approximate Interval Between Onset and Death 5 DAYS | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and Title of certifier Charles M. Benner | | | |
| | 29c. License number D31563 | | | | 29d. Date signed (Month, Day, Year) July 29, 1997 | | | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles M. Benner, M.D. 11251 Lockwood Dr. Silver Spring, Maryland 20901 | | | | | | | |
| | 31. Date filed (Month, Day, Year) JUL 31 1997 | | | | 32. Registrar's Signature Julia Davidson-Randall | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25285

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ragnar W. Forsbacka

2. Date of Death

Month Day Year
July 25, 1997

3. Time of Death

4:00 P.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

5. Social Security Number

578-05-7967

6. Sex

XXM 2□F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
March 26, 1914

9. Birthplace (State or Foreign Country)

Minnesota

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Takoma Park

10d. Inside City Limits

XX Yes 2□ No

10e. Street and Number

502 Elm Ave.

10f. Zip Code

20912

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1□ Never Married 2X Married
3□ Widowed 4□ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1□ Yes 2X No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1□ Yes 2X No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

carpenter

16b. Kind of Business/Industry

construction

17. Father's Name (First, Middle, Last)

John Forsbacka

18. Mother's Name (First, Middle, Maiden Surname)

Anna Hongell

19a. Informant's Name/Relationship (Type, Print)

Agnes S. Forsbacka/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

502 Elm Ave. Takoma Park, MD 20912

20a. Method of Disposition

XX Burial 2□ Cremation 3□ Removal from State
4□ Donation 5□ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

George Washington Cemetery 7/29/97 Adelphi, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Takoma Funeral Home, Inc.
254 Carroll St. NW Washington, DC 2001223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Shock, unknown cause

Approximate
Interval Between
Onset and Death

2 days

Due to (or as a consequence of):

b. Metabolic acidosis

2 days

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

c. Probable abdominal origin, ischemic bowel

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

coronary artery disease

23b. Did tobacco use contribute to the cause of death?

1□ Yes 2X No 3□ Probably 4□ Unknown

24a. Was an autopsy
performed?

1□ Yes 2X No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1□ Yes 2□ No

25. Was case referred to medical
examiner?

1□ Yes 2X No

26. Place of Death (Check only one)

Hospital: 1X Inpatient 2□ ER/Outpatient 3□ DOA

Other:

4□ Nursing Home 5□ Residence 6□ Other (Specify)

27. Manner of Death

1X Natural 5□ Pending
2□ Accident investigation
3□ Suicide 6□ Could not be
4□ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

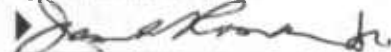
28c. Injury at Work?

1□ Yes 2□ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

MD 16540

29d. Date signed (Month, Day, Year)

July 25, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James A. Ronan, Jr. M.D. 7600 Carroll Ave. Takoma Park, MD 20912

31. Date filed (Month, Day, Year)

JUL 29 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

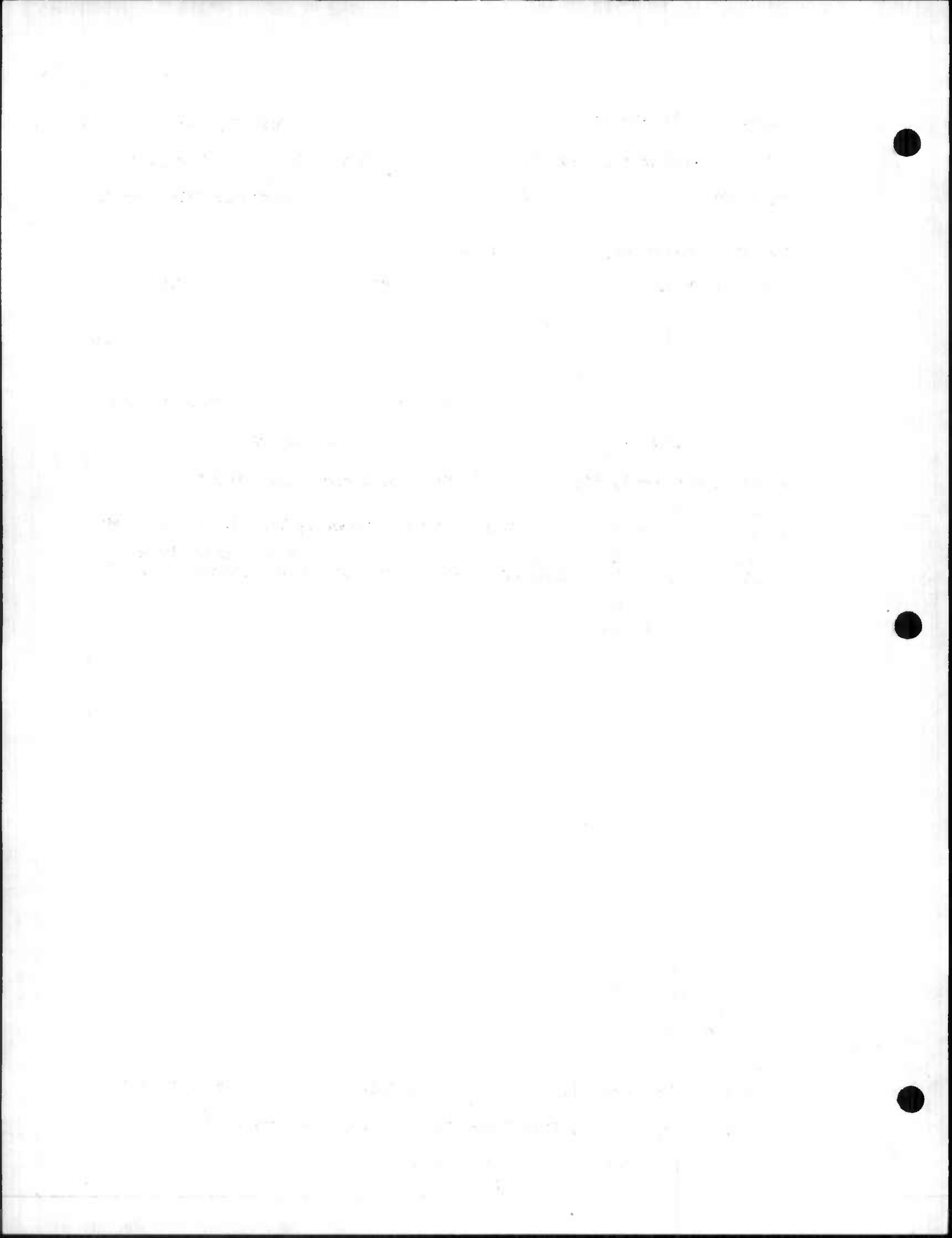
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

12



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25286

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) EDITH M. HOWES FINNEYFROCK | | | | 2. Date of Death Month Day Year July 25 1997 | | 3. Time of Death 11:11 am | |
| | 4a. Facility Name (If not institution, give street and number) Montgomery General Hospital | | | | 4b. City, Town, or Location of Death Olney | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 216-64-4951 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 87 Yrs. | | 8. Date of Birth (Month, Day, Year) Oct. 2, 1909 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Silver Spring | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 13124 Lutes Drive | | 10f. Zip Code 20906 | | 10g. Citizen of What Country? United States | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | | | |
| | 17. Father's Name (First, Middle, Last) Spencer C. Howes | | | | 18. Mother's Name (First, Middle, Maiden Surname) Emma Schriener | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Paul Finneyfrock/son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7025 Rison Drive, Indian Head, Maryland 20640 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Carmel Cemetery | | 20c. Location - City or Town, State Sunshine, Maryland | | 20d. Date 7/29/97 | |
| | 21. Signature of Funeral Service Licensee Roy W. Bauer | | | | 22. Name and Address of Facility Muriel H. Barber Funeral Home P.O. Box 5038, Laytonsville, Maryland 20882 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Pulmonary Edema Due to (or as a consequence of): b. ASAD Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death 3 Hours 10 YEARS | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| | 29b. Signature and Title of certifier Thomas E. Dooley MD | | 29c. License number 016458 | | 29d. Date signed (Month, Day, Year) July 25, 1997 | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas E. Dooley, MD 17904 GEORGIA Avenue OLNEY Md 20832 | | | | | | | |
| | 31. Date filed (Month, Day, Year) JUL 28 1997 | | 32. Registrar's Signature Julia Davidson-Randall | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25287

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Jesse W. Fowler | | | | 2. Date of Death Month Day Year July 20 1997 | | 3. Time of Death 4:50A.M. | |
| | 4a. Facility Name (If not institution, give street and number) Manor Care Nursing Facility | | | | 4b. City, Town, or Location of Death Largo | | 4c. County of Death Prince George's | |
| Funeral Director | 5. Social Security Number 295 07 4004 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 78 Yrs. | | 8. Date of Birth (Month, Day, Year) Oct. 15, 1918 | |
| | 9. Birthplace (State or Foreign Country) Cleveland, OH. | | 10a. State Maryland | | 10b. County Prince George's | | 10c. City, Town or Location Forrestville | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 2301 Brooks Drive | | 10f. Zip Code 20747 | | 10g. Citizen of What Country? United States | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Attorney/Psychologist | | 16b. Kind of Business/Industry U.S. Government | | | |
| | 17. Father's Name (First, Middle, Last) John Fowler | | | | 18. Mother's Name (First, Middle, Maiden Surname) Annabelle Unavailable | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Thelma W. Fowler (Wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2301 Brooks Drive, Forrestville, MD 20747 | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory | | 20c. Location - City or Town, State Beltsville, Maryland | | 20d. Date 7/29/97 | |
| | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility McGuire Funeral Service Inc. 7400 Georgia Ave., N.W., Washington, D.C. 20012 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. carcinoma of prostate with mets. 2 years. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once. | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier <i>[Signature]</i> | | | | 29c. License number D46478 | | 29d. Date signed (Month, Day, Year) 7-22-97 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suresh A. Patel MD 7501 Surratts Rd # 307, Clinton, MD 20735 | | | | | | | |
| | 31. Date filed (Month, Day, Year) JUL 28 1997 | | | | 32. Registrar's Signature <i>[Signature]</i> | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25288

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William Joseph Freburger, Jr.

2. Date of Death
Month Day Year

July 28, 1997

3. Time of Death

4:40 PM

4a. Facility Name (If not institution, give street and number)

207 Hillsboro Drive

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

220-36-5145

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

56

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Oct. 6, 1940

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

207 Hillsboro Drive

10f. Zip Code

20902

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Editor and Writer

16b. Kind of Business/Industry

Publishing

17. Father's Name (First, Middle, Last)

William J. Freburger

18. Mother's Name (First, Middle, Maiden Surname)

Nellie Bagdonas

19a. Informant's Name/Relationship (Type, Print)

Mary Algeo Freburger

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

207 Hillsboro Drive Silver Spring, Maryland 20902

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

8/1/97 Silver Spring, Maryland

21. Signature of Funeral Service Licensee

Andrew J. Cole

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. cardiorespiratory arrest

Approximate Interval Between Onset and Death

immediate

Due to (or as a consequence of):

b. atherosclerotic cardiovascular disease

unknown

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

2 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Medical Examiner

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

G. Peter Pushkas, M.D.

29c. License number

D21531

29d. Date signed (Month, Day, Year)

July 30, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

G. Peter Pushkas, M.D. 11510 Old Georgetown Road Rockville, MD 20852

31. Date filed (Month, Day, Year)

JUL 31 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25289

Items: 10a-c, e, f Per Informant G-751 9/22/97 dh

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

| | | | | | |
|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Dorothy Jean Flores | | 2. Date of Death Month 08 Day 02 Year 1997 | | 3. Time of Death 2220 | |
| 4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center | | | 4b. City, Town, or Location of Death Annapolis | | 4c. County of Death Anne Arundel |
| 5. Social Security Number 549 12 7058 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 79 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 07/02/1918 |
| 9. Birthplace (State or Foreign Country) California | | | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State MN MD | 10b. County Hennipen County | 10c. City, Town or Location Bloomington Annapolis | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 6975 Kenmare Drive | | 10f. Zip Code 55438 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Bookkeeper | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bookkeeper | | 16b. Kind of Business/Industry Electrical Industry | | | |
| 17. Father's Name (First, Middle, Last) Nelson M. Stafford | | | 18. Mother's Name (First, Middle, Maiden Surname) Alice May Wilbur | | |
| 19a. Informant's Name/Relationship (Type, Print) Ronald Flores (son) | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6975 Kenmare Drive, Bloomington MN 55438 | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory | | 20c. Location - City or Town, State 8/4/97 Alexandria VA | |
| 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility Advent Funeral & Cremation Services Annapolis MD 21401 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| Immediate Cause (Final disease or condition resulting in death) pneumonia | | | | | |
| Due to (or as a consequence of): | | | | | |
| Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last emphysema | | | | | |
| Due to (or as a consequence of): | | | | | |
| Due to (or as a consequence of): | | | | | |
| Due to (or as a consequence of): | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier  | | 29c. License number 019838 | | 29d. Date signed (Month, Day, Year) 8/3/97 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Stuart E. Selouch, M.D. 900 Bestgate Annapolis Md. 21401 | | | | | |
| 31. Date filed (Month, Day, Year) AUG 05 1997 | | 32. Registrar's Signature  | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

97 25290

Amend # 11 8/12/97 AA Co Health cms

FOR
STATE
1 - REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Francis Peyton Fuller | | | | 2. DATE OF DEATH MONTH DAY YEAR August 7 1997 | | 3. TIME OF DEATH 4:10AM M | |
| 4. SOCIAL SECURITY NUMBER 212-05-6376 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 83 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) June 17 1914 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | 9a. FACILITY NAME (If not institution, give street and number) Annapolis Nursing & Rehab Center | | 9b. CITY, TOWN OR LOCATION OF DEATH Annapolis | | 9c. COUNTY OF DEATH Anne Arundel | |
| 10a. STATE MD | | 10b. COUNTY Anne Arundel | | 10c. CITY, TOWN OR LOCATION Annapolis | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1 Winslow Court | | | | 10f. ZIP CODE 21403 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Accountant/Computers | | 16b. KIND OF BUSINESS/INDUSTRY Business Systems | | | |
| 17. FATHER'S NAME (First, Middle, Last) Henry Fuller | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lucy Claude | | | |
| 19a. INFORMANT'S NAME (Type/Print) Marie K. Fuller (Wife) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Winslow Court Annapolis, Maryland 21403 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Maryland Veterans Cemetery 8/11/97 | | 20c. LOCATION — City or Town, State Crownsville, Maryland | | 20d. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald L. Taylor</i> | | | | 22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Multiple Myeloma DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | Approximate Interval Between Onset and Death 1 month | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>W. Hochman, MD</i> | | | | 29c. LICENSE NUMBER DO5192 | | 29d. DATE SIGNED (Month, Day, Year) 8/1/97 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Richard I. Hochman, MD 1533A Forest Dr. Annapolis, Md 21408 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) AUG 08 1997 | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25291

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Florence Crusberg Frazier

2. Date of Death

Month Day Year
July 28, 1997

3. Time of Death

4:15 pm

4a. Facility Name (If not institution, give street and number)

208 St. Ives Garth

4b. City, Town, or Location of Death

Severna Park

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

048-12-9025

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 2, 1904

9. Birthplace (State or Foreign Country)

CT

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Severna Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

208 St. Ives Garth

10f. Zip Code

21146

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Gustave Crusberg

18. Mother's Name (First, Middle, Maiden Summa)

Anna Bolinder

19a. Informant's Name/Relationship (Type, Print)

Dr. Robert Frazier/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

208 St. Ives Garth Severna Park, MD 21146

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

July 29 1997

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Barranco & Sons P.A. Severna Park Funeral Home
495 Ritchie Hwy. Severna Park, MD 21146

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a.

Bilateral Cerebral dysfunction

4 days

b.

Due to (or as a consequence of):
Cerebral edema

4 days

c.

Due to (or as a consequence of):
(B) Cerebral hemorrhage

4 days

d.

Due to (or as a consequence of):
Cerebrovascular disease

9 yrs.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George C. SAMANIS 205 Ridgely Ave Annapolis MD 21401

31. Date filed (Month, Day, Year)

32. Registrar's Signature

JUL 31 1997

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

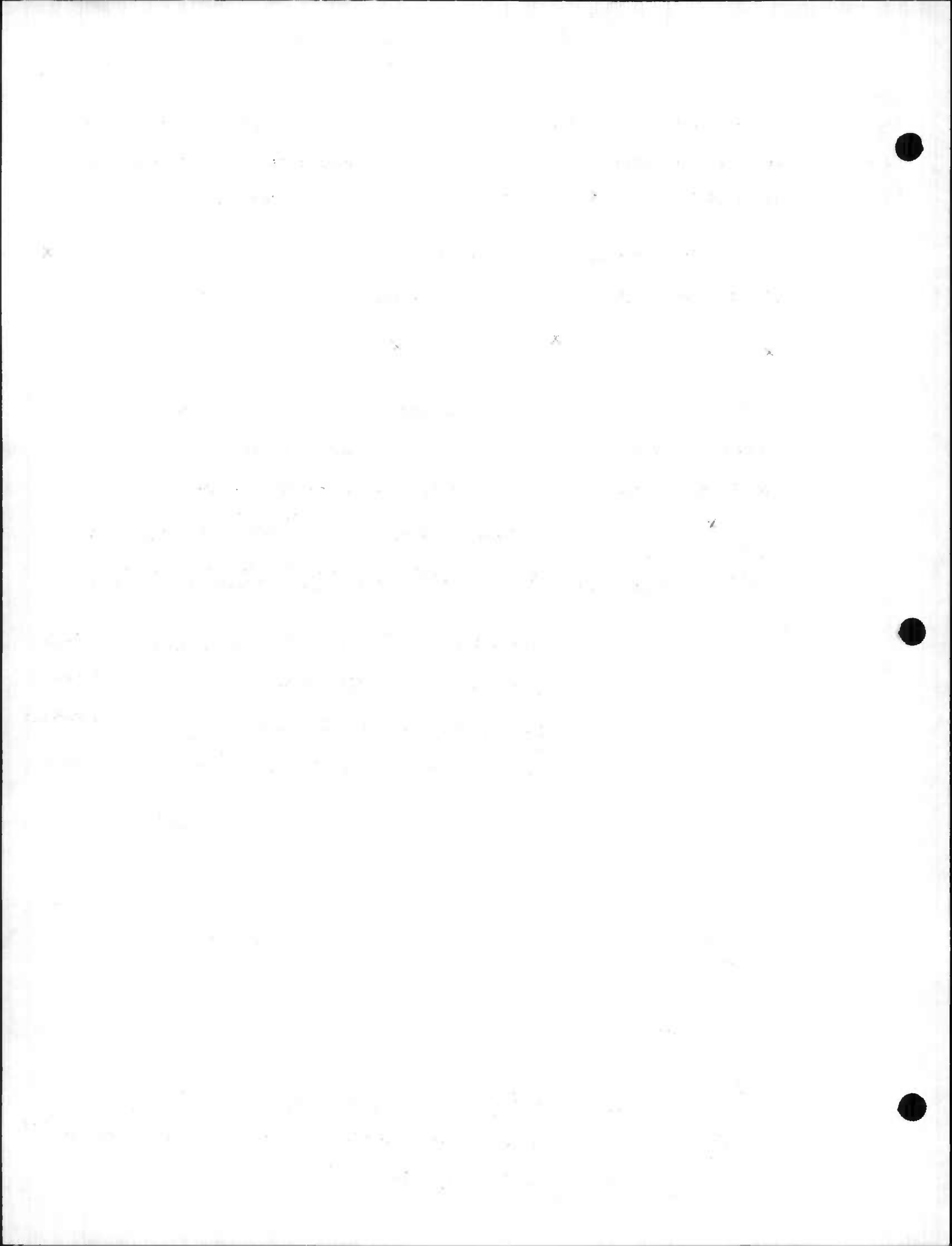
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25292

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|---|---|---|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Catherine Geneva Gibson | | | | 2. Date of Death Month Day Year August 5, 1997 | | | | 3. Time of Death 8:10 pm | |
| | 4e. Facility Name (If not institution, give street and number) Harford Memorial Hospital | | | | 4b. City, Town, or Location of Death Havre de Grace | | | | 4c. County of Death Harford | |
| Funeral Director | 5. Social Security Number 212-22-9384 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 77 Yrs. | | 8. Date of Birth (Month, Day, Year) May 26, 1920 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10e. State Maryland | | 10b. County Harford | | 10c. City, Town or Location Bel Air | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number 2148 Thomas Run Road | | | | 10f. Zip Code 21014 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic Engineer | | | | 16b. Kind of Business/Industry U.S. Government | |
| | 17. Father's Name (First, Middle, Last) Augustus (U/K) Hill | | | | 18. Mother's Name (First, Middle, Maiden Surname) Virginia Laura Wilson | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Gloria Perry-Niece | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 400 Devonshire Court, Aberdeen, MD 21001 | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Clarks U.M. Cemetery | | Date 8-11-97 | | 20c. Location - City or Town, State Bel Air, MD | | | |
| | 21. Signature of Funeral Service Licensee Holly K. McComas | | | | 22. Name and Address of Facility Howard K. McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | |
| | Physician /Medical Examiner | Immediate Cause (Final disease or condition resulting in death) a. Metastatic Ca To the Lung Due to (or as a consequence of): b. Carcinoma - Thyroid Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death 3 mo. 3 mo. | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Carcinoma of Colon | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | |
| | | | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| State Registrar | 29b. Signature and title of certifier Shirley M. [Signature] | | | | 29c. License number D 15994 | | 29d. Date signed (Month, Day, Year) Aug. 6, 1997 | | | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) LETICIA S. GALVEZ, M.D. 625 S. UNION AVE. Havre de Grace Md. 21078 | | | | | | | | | |
| | 31. Date filed (Month, Day, Year) AUG 7 1997 | | | | 32. Registrar's Signature [Signature] | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25293

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GEORGE S. GARDINER

2. Date of Death

Month Day Year
Aug. 4, 1997

3. Time of Death

4:30 PM

4a. Facility Name (If not institution, give street and number)

Physicians Memorial Hospital

4b. City, Town, or Location of Death

La Plata

4c. County of Death

Charles

Funeral
Director

5. Social Security Number

217-09-3246

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

90

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 17, 1906

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

Charlotte Hall

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

Rt. 2 Box 5

10f. Zip Code

20622

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1941-4513. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Salesman

16b. Kind of Business/Industry

Oil Company

17. Father's Name (First, Middle, Last)

Edwin M. Gardiner

18. Mother's Name (First, Middle, Maiden Surname)

Idola Gardiner

19a. Informant's Name/Relationship (Type, Print)

Bob Ager - Stepson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7725 Carol Road, Port Tobacco, MD 20677

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

St. Peter's Cemetery

Date

8-8-97

20c. Location - City or Town, State

Waldorf, MD

21. Signature of Funeral Service Licensee

Shannon Ramirez M00798

22. Name and Address of Facility

Huntt Funeral Home, Inc.
P. O. Box 156, Waldorf, MD 20604-015623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. RENAL FAILURE

Due to (or as a consequence of):

f. HYDRONEPHROSIS

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

FEW MONTHS

FEW MONTHS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Shannon Ramirez Attending

29c. License number

D-44436

29d. Date signed (Month, Day, Year)

August 05 1997

30. Name and address of person who completed cause of death (Item 28e) (Type, Print)

Ashvinkumar J. Patel, MD 603 Post Office Rd., Suite 207, Waldorf, MD 20602

State
Registrar

31. Date filed (Month, Day, Year)

AUG 12 1997

32. Registrar's Signature

Julia Davidson Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25294

Certificate of Death

Reg. No.

| | | | | | |
|--|--|--|---|--------------------------------|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MARGARET H. GARVEY | | 2. Date of Death Month Day Year July 19 97 | | 3. Time of Death 0820 |
| | 4a. Facility Name (If not institution, give street and number) Friends House | | 4b. City, Town, or Location of Death Sandy Spring | | 4c. County of Death Montgomery |
| Funeral Director | 5. Social Security Number 577-28-3593 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 81 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) Nov. 1, 1915 | | 9. Birthplace (State or Foreign Country) Virginia | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | |
| | 10a. State Maryland | 10b. County Montgomery | 10c. City, Town or Location Silver Spring | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| | 10e. Street and Number 15100 Timberlake Drive | | 10f. Zip Code 20904 | | 10g. Citizen of What Country? USA |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cafeteria Manager | | 16b. Kind of Business/Industry Public School | | |
| | 17. Father's Name (First, Middle, Last) Frank P. Hammers | | 18. Mother's Name (First, Middle, Maiden Surname) Alice Carr | | |
| | 19a. Informant's Name/Relationship (Type, Print) Bill Garvey / Son | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt. 5, Box 564, Waynesboro, Virginia 22980 | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cem. | | 20c. Location - City or Town, State Arlington, Virginia |
| | 21. Signature of Funeral Service Licensee <i>Loni Shont-Holland</i> | | 22. Name and Address of Facility Hines-Rinaldi Funeral Home 1800 New Hampshire Avenue Silver Spring, Maryland 20904 | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | |
| | Immediate Cause (Final disease or condition resulting in death) a. METASTATIC BREAST CANCER Due to (or as a consequence of): | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITIS HYPERTENSION CARDIOMEGALY | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M |
| State Registrar | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | |
| | 29b. Signature and title of certifier <i>John E. Glancy MD</i> | | 29c. License number D. 25345 | | 29d. Date signed (Month, Day, Year) 7/19/97 |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN E. GLANCY MD 733 CLOVERLY ST. SILVER SPRING, MD 20905 | | | | |
| 31. Date filed (Month, Day, Year) JUL 29 1997 | | 32. Registrar's Signature <i>Julia Davidson-Rendell</i> | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25295

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MICHAEL ANTHONY GERACE

2. Date of Death

July 30, 1997

3. Time of Death

1:00pm

4a. Facility Name (If not institution, give street and number)

13132 Manor Drive

4b. City, Town, or Location of Death

Mt. Airy

4c. County of Death

Frederick

Funeral
Director

5. Social Security Number

113-16-4944

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 21, 1927

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10e. State

Md.

10b. County

Frederick

10c. City, Town or Location

Mt. Airy

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13132 Manor Drive

10f. Zip Code

21771

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No 1945-
If Yes, Give
Year or Dates: 194613. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Decorator

16b. Kind of Business/Industry

Interior Design

17. Father's Name (First, Middle, Last)

Anthony Gerace

18. Mother's Name (First, Middle, Maiden Surname)

Mary Harvey

19a. Informant's Name/Relationship (Type, Print)

Edna Elizabeth Gerace (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13132 Manor Dr. Mt. Airy, Md. 21771

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metropolitan Crematory

Date

July 31,
1997

20c. Location - City or Town, State

Alexandria, Va.

21. Signature of Funeral Service Licensee

Curtis E. Deep

22. Name and Address of Facility

DeVol Funeral Home
10 East Deer Park Dr. Gaithersburg, Md. 2087723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Non Small Cell Carcinoma of Lung

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

1 year

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Jeremy V. Cooke MD

29c. License number

D08602

29d. Date signed (Month, Day, Year)

7/30/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Jeremy V. Cooke MD 10400 Conn. Ave. Kensington Md. 20897

31. Date filed (Month, Day, Year)

AUG 01 1997

32. Registrar's Signature

John Davidson-Rodriguez

State
Registrar

Baltimore, Maryland 21215-0020

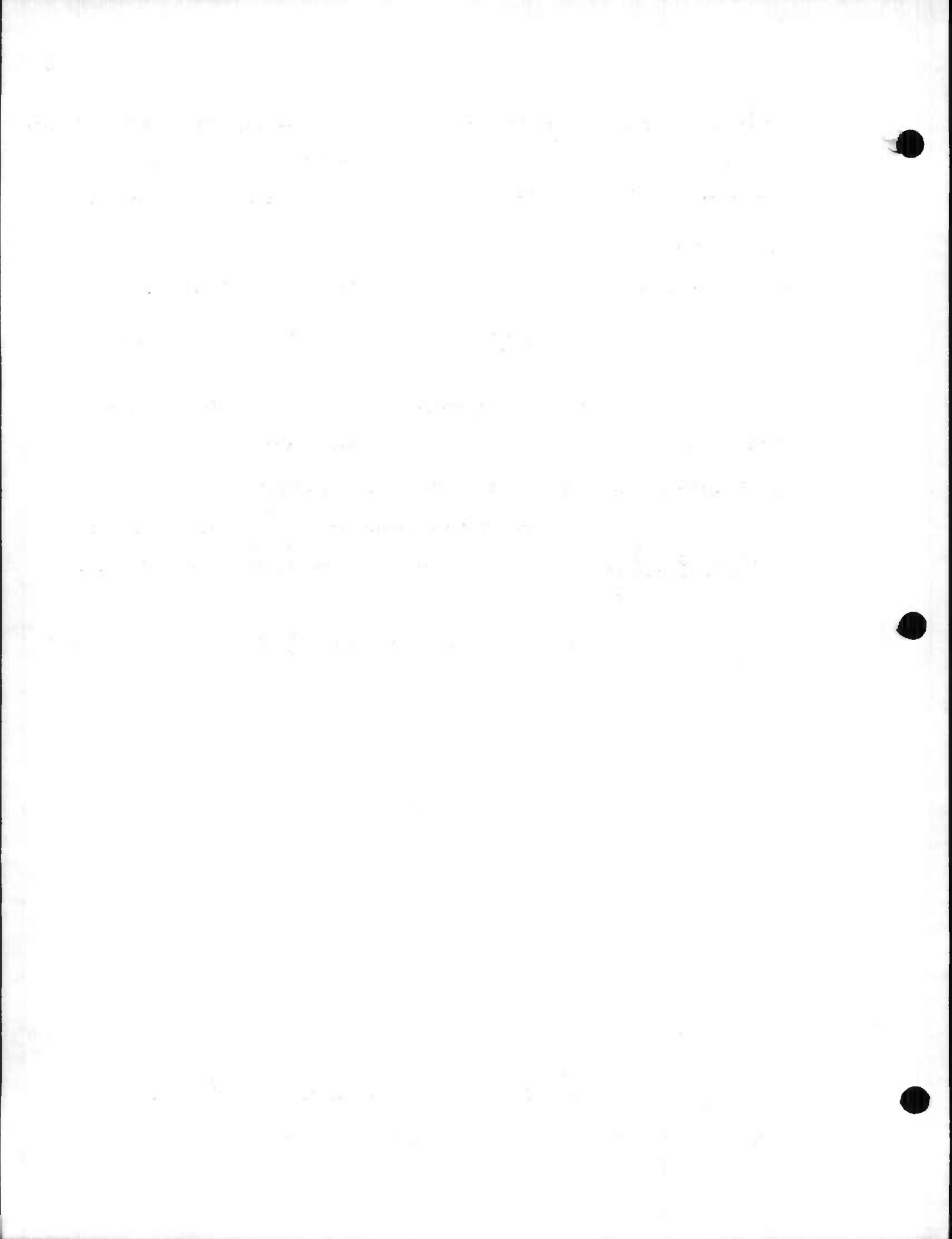
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25296

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|--|--|---|--|--|--|--|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ALETHA WALDRON GOETZGER | | | | 2. Date of Death Month Day Year July 25, 1997 | | 3. Time of Death 10:45 AM | | | | |
| | 4a. Facility Name (If not Institution, give street and number) 13 Dutchess Court | | | | 4b. City, Town, or Location of Death Olney | | 4c. County of Death Montgomery | | | | |
| Funeral Director | 5. Social Security Number 212-24-3955 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 68 Yrs. | | 8. Date of Birth (Month, Day, Year) Feb. 26, 1929 | | | | |
| | 9. Birthplace (State or Foreign Country) Pennsylvania | | 10a. State MD | | 10b. County Montgomery | | 10c. City, Town or Location Olney | | | | |
| Usual Residence of Decedent | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 13 Dutchess Court | | 10f. Zip Code 20832 | | 10g. Citizen of What Country? United States | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Data Entry Clerk | | 16b. Kind of Business/Industry Montgomery Mutual | | 17. Father's Name (First, Middle, Last) David Louis Waldron | | 18. Mother's Name (First, Middle, Maiden Surname) Collette Bell Waldron | | | |
| 19a. Informant's Name/Relationship (Type, Print) Gayle M. Goetzger/daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18028 Rolling Meadow Way, Olney, MD 20832 | | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery | | 20c. Location - City or Town, State 7/28/97 Silver Spring, MD | | | |
| 21. Signature of Funeral Service Licensee <i>Eric Chert-Holbrook</i> | | 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring, MD 20904 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. acute myocardial infarction Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death 10 mins | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | |
| | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28d. Describe how injury occurred | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>John T. ...</i> | | 29c. License number 208546 | |
| 29d. Date signed (Month, Day, Year) July 27, 1997 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John T. ... 8218 W. ... Ave Bethesda | | 31. Data filed (Month, Day, Year) JUL 29 1997 | | 32. Registrar's Signature <i>John Davidson-Rendell</i> | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar

DHMM 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25297

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Bladimir Enrique Granados

2. Date of Death

Month Day Year
July 22, 1997

3. Time of Death

6:30 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

None

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 18, 1997

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12609 Layhill Road, #102

10f. Zip Code

20906

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)XX Yes 2 ☐ No Specify:
El Salvadoran14. Race - American Indian,
Black, White, etc.Specify:
White15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
0

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

None

16b. Kind of Business/Industry

None

17. Father's Name (First, Middle, Last)

Bladimir Masis

18. Mother's Name (First, Middle, Maiden Surname)

Nora A. Granados

19a. Informant's Name/Relationship (Type, Print)

Nora A. Granados

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as 10

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

7-28-97

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

Ellen H. Rapp

22. Name and Address of Facility

Rapp Funeral Services, P. A.
933 Gist Avenue, Silver Spring, MD 2091023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)a. Interventricular Hemorrhage / Intracranial Hemorrhage
Due to (or as a consequence of):b. Severe immaturity - 23 week gestation
Due to (or as a consequence of):c. Severe Respiratory Distress Syndrome
Due to (or as a consequence of):

d. Pulmonary Interstitial Emphysema

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Seizures

Extremely Low Birthweight Neonate

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Sharon A. Kiernan, M.D.

29c. License number

D46711

29d. Date signed (Month, Day, Year)

7/22/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sharon A. Kiernan, M. D., 1500 Forest Glen Road, Silver Spring, MD 20910

31. Date filed (Month, Day, Year)

JUL 30 1997

32. Registrar's Signature

Julia Davidson-Rodriguez

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25298

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Gertrude Gregory

2. Date of Death

Month Day Year
July 27, 1997

3. Time of Death

3:40PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

11509 Piney Lodge Road

4b. City, Town, or Location of Death

North Potomac

4c. County of Death

Montgomery

5. Social Security Number

065-09-0128

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 15, 1910

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

N. Potomac

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11509 Piney Lodge Road

10f. Zip Code

20878

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John Joseph Hesse

18. Mother's Name (First, Middle, Maiden Surname)

Annie Manger

19a. Informant's Name/Relationship (Type, Print)

Richard P. Gregory/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11509 Piney Lodge Road, N. Potomac, MD 20878

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Montgomery Crematorium, Inc.

Date

July 31, 1997

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

Michelle O. Kutta M00348

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/
Rockville, Inc., 300 W. Montgomery Avenue,
Rockville, Maryland 20850-280523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Metastatic Colon Cancer

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

weeks

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hyperthyroidism

Diabetes Mellitus

Ischemic Heart Disease

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending
investigation6 ☐ Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11 ☐12 ☐13 ☐14 ☐15 ☐16 ☐17 ☐18 ☐19 ☐20 ☐21 ☐22 ☐23 ☐24 ☐25 ☐26 ☐27 ☐28 ☐29 ☐30 ☐31 ☐32 ☐33 ☐34 ☐35 ☐36 ☐37 ☐38 ☐39 ☐40 ☐41 ☐42 ☐43 ☐44 ☐45 ☐46 ☐47 ☐48 ☐49 ☐50 ☐51 ☐52 ☐53 ☐54 ☐55 ☐56 ☐57 ☐58 ☐59 ☐60 ☐61 ☐62 ☐63 ☐64 ☐65 ☐66 ☐67 ☐68 ☐69 ☐70 ☐71 ☐72 ☐73 ☐74 ☐75 ☐76 ☐77 ☐78 ☐79 ☐80 ☐81 ☐82 ☐83 ☐84 ☐85 ☐86 ☐87 ☐88 ☐89 ☐90 ☐91 ☐92 ☐93 ☐94 ☐95 ☐96 ☐97 ☐98 ☐99 ☐100 ☐101 ☐102 ☐103 ☐104 ☐105 ☐106 ☐107 ☐108 ☐109 ☐110 ☐111 ☐112 ☐113 ☐114 ☐115 ☐116 ☐117 ☐118 ☐119 ☐120 ☐121 ☐122 ☐123 ☐124 ☐125 ☐126 ☐127 ☐128 ☐129 ☐130 ☐131 ☐132 ☐133 ☐134 ☐135 ☐136 ☐137 ☐138 ☐139 ☐140 ☐141 ☐142 ☐143 ☐144 ☐145 ☐146 ☐147 ☐148 ☐149 ☐150 ☐151 ☐152 ☐153 ☐154 ☐155 ☐156 ☐157 ☐158 ☐159 ☐160 ☐161 ☐162 ☐163 ☐164 ☐165 ☐166 ☐167 ☐168 ☐169 ☐170 ☐171 ☐172 ☐173 ☐174 ☐175 ☐

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25299

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Luis A. Gutierrez

2. Date of Death
Month Day Year

July 28, 1997

3. Time of Death

8:40 am

4e. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

578-64-9661

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

61 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

January 27, 1936

9. Birthplace (State or Foreign Country)

Columbia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5809 Nicholson Lane #716

10f. Zip Code

20852

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☒ Yes 2 ☐ No Specify:

Columbian

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

5+

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Mechanical Engineer

16b. Kind of Business/Industry

Bechtel Corporation

17. Father's Name (First, Middle, Last)

Luis A. Gutierrez

18. Mother's Name (First, Middle, Maiden Summa)

Carmen de los Delores Saavedra

19a. Informant's Name/Relationship (Type, Print)

Olga L. Gutierrez/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5809 Nicholson Lane #716 Rockville, Maryland 20852

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

July 30, 1997

Montgomery Crematorium Inc.

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

M00335

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue
Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. acute myelocytic leukemia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

9 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

021531

29d. Date signed (Month, Day, Year)

July 28, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Victor M. Priego, M.D. 6410 Rockledge Drive # 625 Bethesda, Maryland 20817

31. Date filed (Month, Day, Year)

AUG 01 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25300

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

George R Griggs, Jr.

2. Date of Death

August 9 1997

3. Time of Death

9:30AM

4a. Facility Name (If not institution, give street and number)

110 Sunset Drive

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

212-03-4207

6. Sex

XXM 2□F

7. Age (In yrs. last birthday)

89

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

August 24 1907

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1□ Yes 2□ No

10e. Street and Number

110 Sunset Drive

10f. Zip Code

21403

10g. Citizen of What Country?

United States

11. Marital Status

1□ Never Married 2□ Married
3□ Widowed 4□ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1□ Yes 2□ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1□ Yes 2□ No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Director Of Public Relations

16b. Kind of Business/Industry

Coca-Cola Company

17. Father's Name (First, Middle, Last)

George R. Griggs, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Mary Jennie Bell

19a. Informant's Name/Relationship (Type, Print)

Margaret A. Griggs (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

110 Sunset Drive Annapolis, Maryland 21403

20a. Method of Disposition

1□ Burial 2□ Cremation 3□ Removal from State
4□ Donation 5□ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Ft. Lincoln Crematory /12/97

Date

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

John M. Taylor Funeral Home, Inc.
147 Duke of Gloucester St. Annapolis, MD 2140123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

Ischemic cardiomyopathy

Due to (or as a consequence of):

b.

Coronary arteriosclerosis

Due to (or as a consequence of):

c.

—

Due to (or as a consequence of):

d.

—

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death2 weeks
several
years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus type II

23b. Did tobacco use contribute to the cause of death?

1□ Yes 2□ No 3□ Probably 4□ Unknown

24a. Was an autopsy
performed?

1□ Yes 2□ No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1□ Yes 2□ No

25. Was case referred to medical
examiner?

1□ Yes 2□ No

Hospital: 1□ Inpatient 2□ ER/Outpatient 3□ DOA

26. Place of Death (Check only one)

Other: 4□ Nursing Home 5□ Residence 6□ Other (Specify)

27. Manner of Death

1□ Natural 5□ Pending
investigation
2□ Accident 6□ Could not be
determined
3□ Suicide
4□ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?

1□ Yes 2□ No

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)

29b. Signature and title of certifier

Charles W. Kinzer

29c. License number

D05928

29d. Date signed (Month, Day, Year)

August 9, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Charles W. Kinzer, MD, 2003 Medical Pkwy #100, Annapolis, MD 21401

31. Date filed (Month, Day, Year)

AUG 11 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25301

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIE JAMES GREENE

2. Date of Death

Month

Day

Year

3. Time of Death

06:45 PM

FOUND

4a. Facility Name (If not institution, give street and number)

12202 DILLARD PLACE

4b. City, Town, or Location of Death

FORT WASHINGTON

4c. County of Death

PRINCE GEORGES

5. Social Security Number

577-66-8224

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

48 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
6/17/49

9. Birthplace (State or Foreign Country)

S. Carolina

Usual Residence of Decedent

10a. State

Md.

10b. County

P.G.

10c. City, Town or Location

Ft. Washington

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

12202 Dillard Place

10f. Zip Code

20744

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 69-'71

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Unemployed

16b. Kind of Business/Industry

None

17. Father's Name (First, Middle, Last)

William Norman

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy L. Greene

19a. Informant's Name/Relationship (Type, Print)

Jacquelyn M. Martin/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

434 Burbank St., S.E., Wash., D.C. 20019

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cheltenham Vet's. Cem.

Date

8/8/97

20c. Location - City or Town, State

Cheltenham, Md.

21. Signature of Funeral Service Licensee

Dany H. Pratt

22. Name and Address of Facility

H.S. Washington & Sons, Inc.
4925 Burroughs Ave., N.E.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. CANCER OF THROAT

Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

DME

29c. License number

D33954

29d. Date signed (Month, Day, Year)

JULY 31, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARIO F. GOLIE JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785

31. Date filed (Month, Day, Year)

AUG 07 1997

32. Registrar's Signature

John A. Radell

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25302
Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | | |
|---|--|---|---|--|--|--|---|--|--|--|---|---------------------------------|--|------------------------|----------------|-------------------------------|----------------|----|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>Cora E</i> | | | 2. Date of Death Month <i>August</i> Day <i>4</i> Year <i>1997</i> | | | 3. Time of Death <i>1:06 am</i> | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) <i>Southern Maryland Hospital</i> | | | 4b. City, Town, or Location of Death <i>Clinton</i> | | | 4c. County of Death <i>Prince George's</i> | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number <i>578-36-8552</i> | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) <i>89</i> Yrs. | | 8. Date of Birth (Month, Day, Year) <i>May 9, 1908</i> | | 9. Birthplace (State or Foreign Country) <i>Thompsonville MD</i> | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10e. State <i>MD</i> | | 10b. County <i>Prince George</i> | | 10c. City, Town or Location <i>Capitol Heights, MD</i> | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | |
| | 10e. Street and Number <i>1215 Quo Avenue</i> | | | | 10f. Zip Code <i>20743</i> | | | 10g. Citizen of What Country? <i>USA</i> | | | | | | | | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: <i>Black</i> | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>6th</i> College (1-4or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Domestic</i> | | | 16b. Kind of Business/Industry <i>Private</i> | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last) <i>Grant Green</i> | | | | | 18. Mother's Name (First, Middle, Maiden Surname) <i>Estelle Hill</i> | | | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) <i>Christine Wright/ Daughter</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1215 Quo Ave Capitol Heights MD 20743</i> | | | | | | | | | | | | | |
| | 20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Harmony Cemetery</i> | | | Date <i>8/9/97</i> | | 20c. Location - City or Town, State <i>Landover Maryland</i> | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee <i>Robert Smith 884</i> | | | | 22. Name and Address of Facility <i>Robert G. Mason Funeral Home 1661 Good Hope Rd SE Wash DC 20020</i> | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | |
| | <table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a. <i>Chronic Renal Failure</i></td> <td>Approximate Interval Between Onset and Death <i>Unknown</i></td> </tr> <tr> <td>b. <i>Hypertension</i></td> <td><i>Unknown</i></td> </tr> <tr> <td>c. <i>atrial Fibrillation</i></td> <td><i>Unknown</i></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. <i>Chronic Renal Failure</i> | Approximate Interval Between Onset and Death <i>Unknown</i> | b. <i>Hypertension</i> | <i>Unknown</i> | c. <i>atrial Fibrillation</i> | <i>Unknown</i> | d. |
| Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. <i>Chronic Renal Failure</i> | Approximate Interval Between Onset and Death <i>Unknown</i> | | | | | | | | | | | | | | | | |
| | b. <i>Hypertension</i> | <i>Unknown</i> | | | | | | | | | | | | | | | | |
| | c. <i>atrial Fibrillation</i> | <i>Unknown</i> | | | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic Obstructive pulmonary disease</i> <i>Hypothyroidism</i> | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | |
| 24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury <i>M</i> | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | | | |
| 29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier <i>Arastoo Yazdani MD</i> | | | 29c. License number <i>050454</i> | | 29d. Date signed (Month, Day, Year) <i>August, 4, 1997</i> | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Arastoo Yazdani, M.D. 1328 Southern Ave. Washington DC</i> | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) <i>AUG 07 1997</i> | | | 32. Registrar's Signature <i>Juanita K. Randall</i> | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

97 25303

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MARY DELORIS GRAVETTE | | | | 2. DATE OF DEATH MONTH 8 DAY 1 YEAR 97 | | 3. TIME OF DEATH 3:45A M | |
| 4. SOCIAL SECURITY NUMBER 578-38-9381 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 68 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 8-27-28 | |
| 8. BIRTHPLACE (State or Foreign Country) Washington, D.C. | | | | 9a. FACILITY NAME (If not institution, give street and number) 301 BEVERLY CT. | | 9b. CITY, TOWN OR LOCATION OF DEATH FT. WASHINGTON | |
| 9c. COUNTY OF DEATH PRINCE GEO. | | | | 10a. STATE Maryland | | 10b. COUNTY Prince George | |
| 10c. CITY, TOWN OR LOCATION Ft. Washington | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 301 Beverly Ct. | |
| 10f. ZIP CODE 20744 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | 16b. KIND OF BUSINESS/INDUSTRY Home | |
| 17. FATHER'S NAME (First, Middle, Last) George H. Jackson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Agnes Washington | | | |
| 19a. INFORMANT'S NAME (Type/Print) Selena Grady | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 301 Beverly Ct., Ft. Washington Md. | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Harmony Memo. Park 8-6-97 | | 20c. LOCATION — City or Town, State Hyattsville, Md | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James A. Maiter</i> | | | | 22. NAME AND ADDRESS OF FACILITY Universal Mortuary Inc. 411 Kennedy St., N.W. Washington, D.C. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → cerebral edema Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): brain metastases c. DUE TO (OR AS A CONSEQUENCE OF): small cell lung cancer d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 96 hrs 30 days | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE NOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>thg md</i> | | | | 29c. LICENSE NUMBER D-21607 | | 29d. DATE SIGNED (Month, Day, Year) 8/1/97 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) #405 Thomas P. Gage, MD 10905 Ft. Washington Rd, Ft. Washington, Md. 20744 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) AUG 06 1997 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

97-4258-031

CMK

KEONA GRIER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25304

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Keona Grier

2. Date of Death
Month Day Year
JULY 31, 19973. Time of Death
2241PMFuneral
Director

4a. Facility Name (If not institution, give street and number)

398 NORTH SUMMITT AVENUE 202

4b. City, Town, or Location of Death

GAITHERSBURG

4c. County of Death

MONTGOMERY COUNTY

5. Social Security Number

218-37-6213

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

4 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

12-18-92

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

398 North Summitt Avenue Apt. # 202

10f. Zip Code

20877

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

N/A

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Harold Grier, Jr.

18. Mother's Name (First, Middle, Maiden Surname)

LaTonya Robinson

19a. Informant's Name/Relationship (Type, Print)

LaTonya Grier/ Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

910 Palmer Rd. #3 Ft. Washington, Maryland 20744

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Harmony Mem. Park

Date

8/5/97

20c. Location - City or Town, State

Landover, Maryland

21. Signature of Funeral Service Licensee

Nancy A. Perentis

22. Name and Address of Facility

J.B. Jenkins Funeral Home

7474 Landover Rd. Landover, Maryland 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e.

Gunshot Wound of Head

Due to (or as a consequence of):

Sequitely list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☒ Homicide28a. Date of Injury
(Month, Day Year)

7/3/97

28b. Time of
Injury

2240 PM

28c. Injury at
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

subject shot

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

Home

28f. Location (Street and Number or Rural Route Number,
City or Town, State)398 N. Summitt Ave
Gaithersburg, Md29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Dennis J. Chute, MD

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

AUGUST 01, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dennis J. Chute, MD

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

AUG 05 1997

32. Registrar's Signature

John Anderson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

97-4257-031

CMK

LATOYA GRIER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25305

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|--|---|--|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) LaToya Grier | | | | | | 2. Date of Death Month Day Year JULY 31, 1997 | | 3. Time of Death 2240PM | |
| | 4a. Facility Name (If not institution, give street and number) 398 NORTH SUMMITT AVENUE 202 | | | | | | 4b. City, Town, or Location of Death GAITHERSBURG | | 4c. County of Death MONTGOMERY COUNTY | |
| Funeral Director | 5. Social Security Number 212-25-9720 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 8 Yrs. | | 8. Date of Birth (Month, Day, Year) 06-24-89 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Gaithersburg | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| To Be Completed by Funeral Director | 10e. Street and Number 398 North Summitt Avenue Apt. # 202 | | 10f. Zip Code 20877 | | 10g. Citizen of What Country? U.S.A. | | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| | 11. Merital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2nd | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Student | | 16b. Kind of Business/Industry Government | | 17. Father's Name (First, Middle, Last) Harold Grier, Jr. | | 18. Mother's Name (First, Middle, Maiden Surname) LaTonya Robinson | |
| | 19a. Informant's Name/Relationship (Type, Print) LaTonya Grier/ Mother | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 910 Palmer Rd. #3 Ft. Washington, Maryland 20744 | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Mem. Park | | 20c. Location - City or Town, State 8/5/97 Landover, Maryland | |
| Physician /Medical Examiner | 21. Signature of Funeral Service Licensee Nancy A. Perentis | | 22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Rd. Landover, Maryland | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. e. Gunshot Wound of Head Due to (or as a consequence of): | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 23c. Describe how injury occurred subject shot | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. e. Gunshot Wound of Head Due to (or as a consequence of): | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 23c. Describe how injury occurred subject shot | | 23d. Location (Street and Number or Rural Route Number, City or Town, State) 398 N. Summitt Ave Gaithersburg, Md | | 23e. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | |
| | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 7-31-97 | | 28b. Time of Injury 2240 M | |
| To Be Completed by Physician/Medical Examiner | 28a. Date of Injury (Month, Day, Year) 7-31-97 | | 28b. Time of Injury 2240 M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred subject shot | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) 398 N. Summitt Ave Gaithersburg, Md | |
| | 28a. Date of Injury (Month, Day, Year) 7-31-97 | | 28b. Time of Injury 2240 M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred subject shot | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) 398 N. Summitt Ave Gaithersburg, Md | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Dennis J. Chute, MD | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) AUGUST 01, 1997 | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dennis J. Chute, MD 111 Penn Street, Baltimore, Maryland 21201 | |
| | 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Dennis J. Chute, MD | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) AUGUST 01, 1997 | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dennis J. Chute, MD 111 Penn Street, Baltimore, Maryland 21201 | |
| To Be Completed by Physician/Medical Examiner | 31. Date filed (Month, Day, Year) AUG 05 1997 | | 32. Registrar's Signature John A. [Signature] | | 33. Date of Death (Month, Day, Year) JULY 31, 1997 | | 34. Time of Death 2240PM | | 35. Place of Death (City, Town, or Location) GAITHERSBURG | |
| | 31. Date filed (Month, Day, Year) AUG 05 1997 | | 32. Registrar's Signature John A. [Signature] | | 33. Date of Death (Month, Day, Year) JULY 31, 1997 | | 34. Time of Death 2240PM | | 35. Place of Death (City, Town, or Location) GAITHERSBURG | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|---|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Harold Grier, Jr. | | | | 2. Date of Death Month Day Year JULY 31, 1997 | | 3. Time of Death 2240PM | |
| | 4e. Facility Name (If not institution, give street and number) 398 NORTH SUMMITT AVENUE 202 | | | | 4b. City, Town, or Location of Death GAITHERSBURG | | 4c. County of Death MONTGOMERY COUNTY | |
| Funeral Director | 5. Social Security Number 577-80-0943 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 40 Yrs. | | 8. Date of Birth (Month, Day, Year) 02-12-57 | |
| | 9. Birthplace (State or Foreign Country) Washington, D.C. | | 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Gaithersburg | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 398 North Summitt Avenue Apt. # 202 | | 10f. Zip Code 20877 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) 10th | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Stock Clerk | | 16b. Kind of Business/Industry Private | | 17. Father's Name (First, Middle, Last) Harold Grier, Sr. | |
| | 18. Mother's Name (First, Middle, Maiden Surname) Mary Winestock | | 19a. Informant's Name/Relationship (Type, Print) LaTonya Grier/ Wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 910 Palmer Rd. #3 Ft. Washington, Maryland 20744 | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Mem. Park | | 20c. Date 8/5/97 | | 20d. Location - City or Town, State Landover, Maryland | | 21. Signature of Funeral Service Licensee Nancy A. Perentie | |
| | 22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Rd. Landover, Maryland 20785 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Contact Gunshot Wound of Head | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide | |
| | 28a. Date of Injury (Month, Day Year) 7/31/97 | | 28b. Time of Injury 2240 PM | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred self-inflicted gunshot | |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Home | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 398 N. Summitt Ave Gaithersburg, Md | | 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Dennis J. Chute MD | |
| | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) AUGUST 01, 1997 | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201 | | 31. Date filed (Month, Day, Year) AUG 05 1997 | |
| 31. Registrar's Signature J. J. [Signature] | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar

AM
ALLISON
HICKEY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25307

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Allison Mackenna Hickey

2. Date of Death

Month Day Year
AUGUST 05, 1997

3. Time of Death

3:00 P

Funeral
Director

4a. Facility Name (If not institution, give street and number)

JOHNS HOPKINS HOSPITAL PICU

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

5. Social Security Number

212-47-7634

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

1 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Mar. 14, 1996

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Harford

10c. City, Town or Location

Joppa

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

644 Shore Drive

10f. Zip Code

21085

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
n/a

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

n/a

16b. Kind of Business/Industry

n/a

17. Father's Name (First, Middle, Last)

Michael Clifford Hickey III

18. Mother's Name (First, Middle, Maiden Surname)

Melanie Marie Ball

19a. Informant's Name/Relationship (Type, Print)

Michael Hickey III, Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3809 Maryland Avenue, Abingdon, Maryland 21009

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Mt. Erin Catholic Cemetery 8/9/97

Date

20c. Location - City or Town, State

Havre de Grace, Md.

21. Signature of Funeral Service Licensee

Howard K. McComas

22. Name and Address of Facility

Howard K. McComas III Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, Maryland 2100923a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Head Injuries
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

28. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
investigation
2 ☒ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)
8-4-9728b. Time of
Injury

16 02 M

28c. Injury at
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Fall
from window28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

Hotel

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

1422 2nd St Ocean City

29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David R Fowler

29c. License number

OCME

29d. Date signed (Month, Day, Year)

AUGUST , 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

David R Fowler 111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

AUG 7 1997

32. Registrar's Signature

John Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25308

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|---|--|--|---|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) WILLIAM ESTIL HOWELL | | | | 2. Date of Death Month AUGUST Day 6 , Year 1997 | | 3. Time of Death 6:47 PM | |
| | 4a. Facility Name (If not institution, give street and number) PHYSICIANS MEMORIAL HOSPITAL | | | | 4b. City, Town, or Location of Death LA PLATA | | 4c. County of Death CHARLES | |
| Funeral Director | 5. Social Security Number 498-36-6758 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 61 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) NOVEMBER 28, 1935 | | 9. Birthplace (State or Foreign Country) MISSOURI |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10e. State MARYLAND | | 10b. County CHARLES | | 10c. City, Town or Location WALDORF | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number 327 BARKSDALE AVE. | | | | 10f. Zip Code 20602 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1/1995-3/1979 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MECHANIC | | 16b. Kind of Business/Industry PRINTING | | | |
| | 17. Father's Name (First, Middle, Last) CARL S. HOWELL | | | | 18. Mother's Name (First, Middle, Maiden Surname) LOUISE PAINTER | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) BARBARA ANN HOWELL/WIFE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 327 BARKSDALE AVE., WALDORF, MARYLAND 20602 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) TRINITY MEMORIAL GARDENS | | Date 8/11/1997 | | 20c. Location - City or Town, State WALDORF, MARYLAND | |
| | 21. Signature of Funeral Service Licensee MARK G. BROHAWN | | 22. Name and Address of Facility THE HUNTT FUNERAL HOME, INC., POST OFFICE BOX 156, WALDORF, MARYLAND 20604 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last years | | | | | | | |
| | | | | | | | | |
| State Registrar | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Howard Mark Haft, MD | | 29c. License number 027346 | | 29d. Date signed (Month, Day, Year) 8/7/97 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) HOWARD MARK HAFT, MD, 100 OLD LINE CTR., #100, WALDORF, MARYLAND 20602 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 12 1997 | | | | 32. Registrar's Signature Jolin Davidson Randall | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

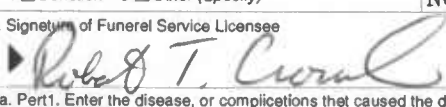
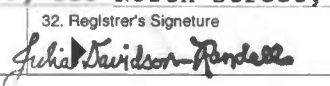
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25309

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|---|---|--|--|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Elsie Town Hall | | | | 2. Date of Death Month August Day 4 Year 1997 | | 3. Time of Death 1117 | | |
| | 4a. Facility Name (If not institution, give street and number) Union Hospital of Cecil County | | | | 4b. City, Town, or Location of Death Elkton | | 4c. County of Death Cecil | | |
| Funeral Director | 5. Social Security Number 165-09-6246 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 80 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) March 25, 1917 | 9. Birthplace (State or Foreign Country) Massachusetts | |
| | Usual Residence of Decedent | | | | 10e. State Maryland | | 10b. County Cecil | | 10c. City, Town or Location North East |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 690 Hances Point Road | | 10f. Zip Code 21901 | | 10g. Citizen of What Country? United States | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher's Aide | | 16b. Kind of Business/Industry Public Elementary Schools | | | |
| 17. Father's Name (First, Middle, Last) Robert F. Town | | | | 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth E. Spedding | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Willis S. Hall / Spouse | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 690 Hances Point Road, North East, MD 21901 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) North East Methodist Cem. | | Date Aug. 9 1997 | | 20c. Location - City or Town, State North East, Maryland | | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, MD 21901 | | | | | |
| 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Aspiration pneumonia w/ sepsis Due to (or as a consequence of): b. Multi infarct dementia Due to (or as a consequence of): c. Hypertension Due to (or as a consequence of): d. | | | | | | | | Approximate Interval Between Onset and Death Days. | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier  | | 29c. License number D45155 | | 29d. Date signed (Month, Day, Year) 08/06/97 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) John R. Mulvey, M.D., 118 North Street, Elkton, MD 21921 410-398-3041 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 07 1997 | | 32. Registrar's Signature  | | | | | | | |

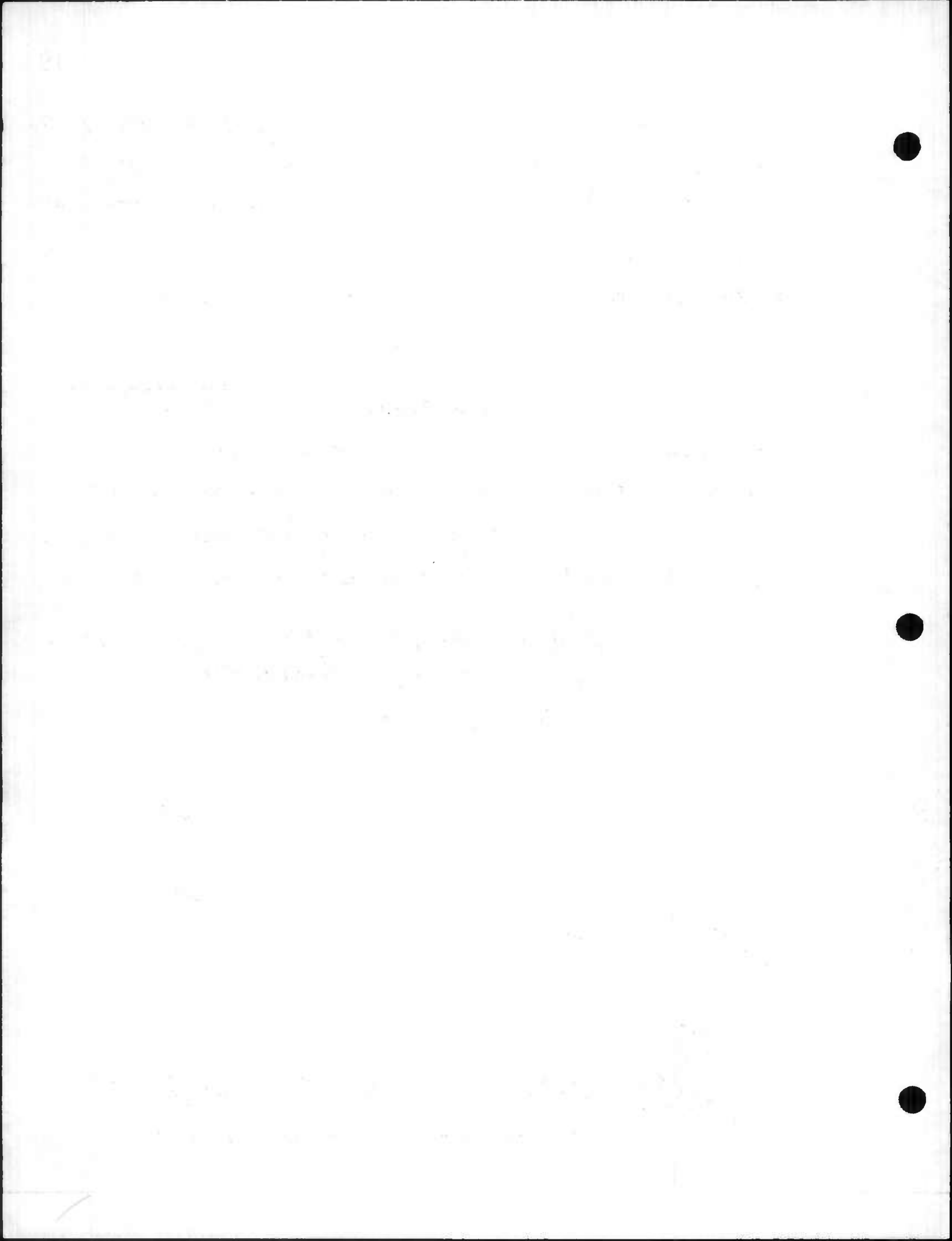
To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25310

Certificate of Death

Reg. No.

| | | | | | | | | |
|-------------------------------------|--|--|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Charlotte L. Hamilton | | | | 2. Date of Death Month Day Year August 7 1997 | | 3. Time of Death 4:50 am | |
| | 4a. Facility Name (If not Institution, give street and number) 101 Shady Beach Road | | | | 4b. City, Town, or Location of Death North East | | 4c. County of Death Cecil | |
| Funeral Director | 5. Social Security Number 217-80-4646 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 69 Yrs. | | 8. Date of Birth (Month, Day, Year) March 10, 1928 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10. Usual Residence of Decedent 10a. State: Maryland 10b. County: Cecil 10c. City, Town or Location: North East 10d. Inside City Limits: 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| To Be Completed by Funeral Director | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 9 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | |
| | 16b. Kind of Business/Industry Her own home | | 17. Father's Name (First, Middle, Last) Edward Wharton | | 18. Mother's Name (First, Middle, Maiden Surname) Fannie Patchell | | 19. Informant's Name/Relationship (Type, Print) Charlotte D. Hamilton/Daughter | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) North East Methodist Cem. | | 20c. Location - City or Town, State 1997 North East, Maryland | | 21. Signature of Funeral Service Licensee | |
| | 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, MD 21901 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Cirrhosis Liver</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death years | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Non Insulin Dependent Diabetes Mellitus</u> | |
| Physician /Medical Examiner | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <u>Sachdev S MD</u> | | 29c. License number D23322 | | 29d. Date signed (Month, Day, Year) 8/7/97 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 118 North St, Suite 8B, ELKTON MD 21921 | | 31. Date filed (Month, Day, Year) AUG 07 1997 | | 32. Registrar's Signature <u>Julia Davidson-Randall</u> | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25311

Certificate of Death

Reg. No.

| | | | | | |
|---|---|--|--|--------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>Susan</i> | | 2. Date of Death Month <i>July</i> Day <i>24</i> Year <i>1997</i> | | 3. Time of Death <i>0603A</i> |
| | 4e. Facility Name (If not institution, give street and number) <i>SHADY GROVE ADVENTIST HOSPITAL</i> | | 4b. City, Town, or Location of Death <i>ROCKVILLE</i> | | 4c. County of Death <i>MONTGOMERY</i> |
| Funeral Director | 5. Social Security Number <i>285-34-2244</i> | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) <i>58</i> Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) <i>May 8, 1939</i> | | 9. Birthplace (State or Foreign Country) <i>Pennsylvania</i> | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | |
| | 10a. State <i>Maryland</i> | 10b. County <i>Montgomery</i> | 10c. City, Town or Location <i>Rockville</i> | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number <i>1301 Matthews Drive</i> | | 10f. Zip Code <i>20851</i> | | 10g. Citizen of What Country? <i>United States</i> |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: <i>White</i> | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>0</i> | | |
| To Be Completed by Physician/Medical Examiner | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Office Assistant</i> | | 16b. Kind of Business/Industry <i>Aviation Publishing</i> | | |
| | 17. Father's Name (First, Middle, Last) <i>James Hubert Ansell</i> | | 18. Mother's Name (First, Middle, Maiden Surname) <i>Garnet Hamilton</i> | | |
| | 19a. Informant's Name/Relationship (Type, Print) <i>Ellis H. Hammond / Husband</i> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1301 Matthews Drive, Rockville, Maryland 20851</i> | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Parklawn Cemetery</i> | | 20c. Location - City or Town, State <i>Rockville, Maryland</i> |
| | 21. Signature of Funeral Service Licensee <i>Roy W. Barber</i> | | 22. Name and Address of Facility <i>Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, Maryland 20882</i> | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <i>Metastatic Carcinoma of Left Lung</i> Due to (or as a consequence of): <i>11 MONTHS</i> | | | | | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Possible Staphylococcal Sepsis</i> | | | | | |
| 23c. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | | |
| 28a. Date of Injury (Month, Day, Year) | | | | | |
| 28b. Time of Injury <i>M</i> | | | | | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 28d. Describe how injury occurred | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier <i>James A. Brown, MD</i> | | | | | |
| 29c. License number <i>D07285</i> | | | | | |
| 29d. Date signed (Month, Day, Year) <i>JULY 24, 1997</i> | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>JAMES A. BROWN, MD 9707 MEDICAL CENTER DR. ROCKVILLE MARYLAND 20850</i> | | | | | |
| 31. Date filed (Month, Day, Year) <i>JUL 28 1997</i> | | | | | |
| 32. Registrar's Signature <i>Julia Davidson-Randall</i> | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25312

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Edyth M. Harouff

2. Date of Death

Month Day Year
July 24, 1997

3. Time of Death

3:15 PM

4e. Facility Name (If not institution, give street and number)

Potomac Valley Nursing Home

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

577-24-2916

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 17, 1915

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1235 Potomac Valley Road

10f. Zip Code

20850

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

-

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Contract Supervisor

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Greenberry Mayhugh

18. Mother's Name (First, Middle, Maiden Surname)

Lela (Not Available)

19a. Informant's Name/Relationship (Type, Print)

Ronald D. DeLisi/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

38 Woodlane Road, Lawrenceville, NJ 08648

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Montgomery Crematorium, Inc

Date

July 25, 1997

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

MO0689

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/
Rockville, Inc. 300 West Montgomery Avenue,
Rockville, Maryland 20850-280523a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or head failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Aspiration Pneumonia

Due to (or as a consequence of):

b. Organic Brain Syndrome

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

1 day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24e. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28e. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D01120

29d. Date signed (Month, Day, Year)

July 25, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Walter Goozh, M.D.

1299 Lamberton Drive, Silver Spring, Maryland 20902

31. Date filed (Month, Day, Year)

AUG 01 1997

32. Registrar's Signature

Julia Davidson-Rodriguez

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

97-4195-031
CIP
JASON HORN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25313

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be dated for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) JASON HORN | | | | 2. Date of Death Month JULY Day 28, Year 1997 | | | | 3. Time of Death 5:20AM | |
| 4a. Facility Name (If not institution, give street and number) 15908 MAPLE RIDGE ROAD | | | | 4b. City, Town, or Location of Death SILVER SPRING | | | | 4c. County of Death MONTGOMERY | |
| 5. Social Security Number 072-24-0613 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 76 Yrs. | | 8. Date of Birth (Month, Day, Year) Dec. 24, 1920 | | 9. Birthplace (State or Foreign Country) Canada | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Silver Spring | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 10e. Street and Number 15908 Maple Ridge Court | | | | 10f. Zip Code 20854 | | 10g. Citizen of What Country? U.S.A. | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4 or 5+) 5+ | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Foreign Affairs Officer | | | | 16b. Kind of Business/Industry Government | |
| 17. Father's Name (First, Middle, Last) Jack Max Horn | | | | 18. Mother's Name (First, Middle, Maiden Surname) Esther Zeitchick | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Josephine Horn | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15115 Interlachen Dr. Silver Spring, MD 20906 | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) King David Mem. Gdns. | | Data 7/30/97 | | 20c. Location - City or Town, State Falls Church, VA | | | |
| 21. Signature of Funeral Services Licensee | | | | 22. Name and Address of Facility Ives-Pearson Funeral Homes 472 N. Washington St. Falls Church, VA | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. POSITIONAL ASPHYXIA Dua to (or as a consequence of): b. Dua to (or as a consequence of): c. Dua to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PARKINSONS DISEASE ALZHIEMERS DISEASE SEIZURE DISORDER | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed? XX Yes 2 <input type="checkbox"/> No | |
| 24b. Were autopsy findings available prior to completion of cause of death? XX Yes 2 <input type="checkbox"/> No | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 26. Place of Death (Check only one) | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accidental 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicidal 4 <input type="checkbox"/> Homicidal | | 28a. Date of Injury (Month, Day Year) 7/28/1997 | | 28b. Time of Death 5:20AM | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred SUBJECT SLID DOWN SIDE OF BED | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) NURSING HOME | | 28e. Location (Street and Number or Rural Route Number, City, Town, State) 15908 MAPLE RIDGE COURT ROCKVILLE, MARYLAND | | | | | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Stephen S. Radentz, M.D. | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) JULY 29, 1997 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEPHEN S. RADENTZ M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 01 1997 | | 32. Registrar's Signature Richard Davidson-Randall | | | | | | | |

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25314

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ELLA M. HOY

2. Date of Death

Month JULY Day 28, Year 1997

3. Time of Death

3:33 AM

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

5. Social Security Number

218-20-2117

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

76

8. Date of Birth (Month, Day, Year)

July 17, 1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Clarksburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

22615 Frederick Road

10f. Zip Code

20871

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

7th

College (1-4 or 5+)

Domestic

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

William E. Brown

18. Mother's Name (First, Middle, Maiden Surname)

Bessie M. Jenkins

19a. Informant's Name/Relationship (Type, Print)

Dorothy Disney (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

22615 Frederick Rd., Clarksburg, MD 20871

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

John Wesley Church Cem. 8/1/97 Clarksburg, MD

21. Signature of Funeral Service Licensee

George R. Snowden

22. Name and Address of Facility

SNOWDEN FUNERAL HOME, P.A.
ROCKVILLE, MD 20850

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Rupture of myocardium
Due to (or as a consequence of):

Minutes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Acute myocardial infarction
Due to (or as a consequence of):

Minutes

c. Chronic Renal Failure
Due to (or as a consequence of):

Days

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. Signature and title of certifier

Deborah Shueless

29d. License number

0369779

29e. Date signed (Month, Day, Year)

July 28, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deborah Shueless 9901 Media Center Rd. Rockville, MD 20850

31. Date filed (Month, Day, Year)

JUL 31 1997

32. Registrar's Signature

*John Davidson-Randall*State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25315

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HAROLD J. HIMMELBERGER

2. Date of Death

Month Day Year
July 27, 1997

3. Time of Death

7:00 P.M.

4a. Facility Name (If not institution, give street and number)

12637 Georgia Avenue

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

205-05-8356

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 3, 1921

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10e. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

12637 Georgia Avenue

10f. Zip Code

20906

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married☐ Widowed ☒ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

☒ Yes ☐ No 1942-

If Yes, Give Year or Dates: 1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Design Engineer

16b. Kind of Business/Industry

Technologies

17. Father's Name (First, Middle, Last)

Erving Himmelberger

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Romig

19a. Informant's Name/Relationship (Type, Print)

Barbara Henery - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3420 Canberra Street, Silver Spring, Maryland 20904

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Fort Lincoln Crematory

Date

8-1-97

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hines-Rinaldi Funeral Home, Inc.

11800 New Hampshire Ave., Silver Spring, MD 20904

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Small Cell Carcinoma of Lung

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Lung Disease

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

26. Place of Death (Check only one)

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jeremy Coule 10400 Conn Ave Kensington MD 20815

31. Date filed (Month, Day, Year)

JUL 30 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25316

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Theron Winfred Held, Sr.

2. Date of Death

Month Day Year
July 26, 1997

3. Time of Death

10:35P.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

4217 Wicomico Avenue

4b. City, Town, or Location of Death

Beltsville

4c. County of Death

Prince George's

5. Social Security Number

304-05-1638

6. Sex

XXM 2□F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 12, 1917

9. Birthplace (State or Foreign Country)

Indiana

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Beltsville

10d. Inside City Limits

1□ Yes 2XX No

10a. Street and Number

4217 Wicomico Avenue

10f. Zip Code

20705

10g. Citizen of What Country?

United States

11. Marital Status

1□ Never Married 2XX Married

3□ Widowed 4□ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

2XX Yes 2□ No

If Yes, Give Year or Dates:

WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1□ Yes 2XX No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

Collage (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Purchaser

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Fred

Held

18. Mother's Name (First, Middle, Maiden Surname)

Cora

Jane

Collins

19a. Informant's Name/Relationship (Type, Print)

Theron W. Held, Jr. (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9511 Red Rain Path Columbia, Maryland 21046

20a. Method of Disposition

1XX Burial 2□ Cremation 3□ Removal from State

4□ Donation 5□ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

7/30/1997

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

Donald V. Borgwardt

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, P.A.

4400 Powder Mill Rd. Beltsville, Maryland 20705

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a.

Pneumonia Failure

Due to (or as a consequence of):

b.

Postoperative, Abdominal Aortic

Due to (or as a consequence of):

c.

Aneurysm

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter underlying cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1□ Yes 2XX No 3□ Probably 4□ Unknown

24a. Was an autopsy performed?

1□ Yes 2XX No

24b. Were autopsy findings available prior to completion of cause of death?

1□ Yes 2XX No

25. Was case referred to medical examiner?

1□ Yes 2XX No

Hospital:

1□ Inpatient

2□ ER/Outpatient

3□ DOA

Other:

4□ Nursing Home

5XX Residence

8□ Other (Specify)

27. Manner of Death

1XX Natural

2□ Accident

3□ Suicide

4□ Homicide

5□ Pending Investigation

6□ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1□ Yes 2XX No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

July 28, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joselito Magday, M.D. 11701 Roby Ave. Beltsville, Maryland 20705

31. Date filed (Month, Day, Year)

JUL 31 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

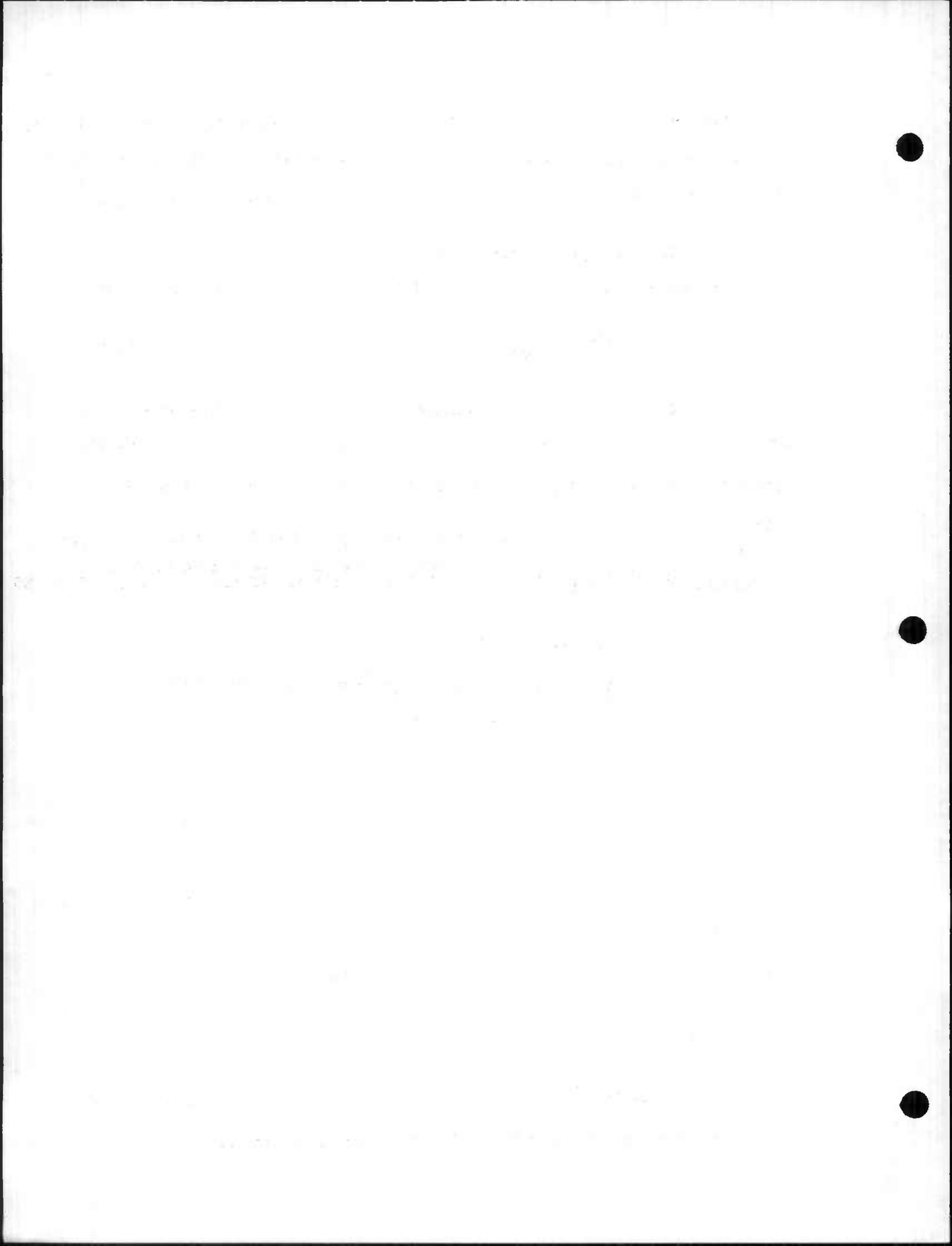
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



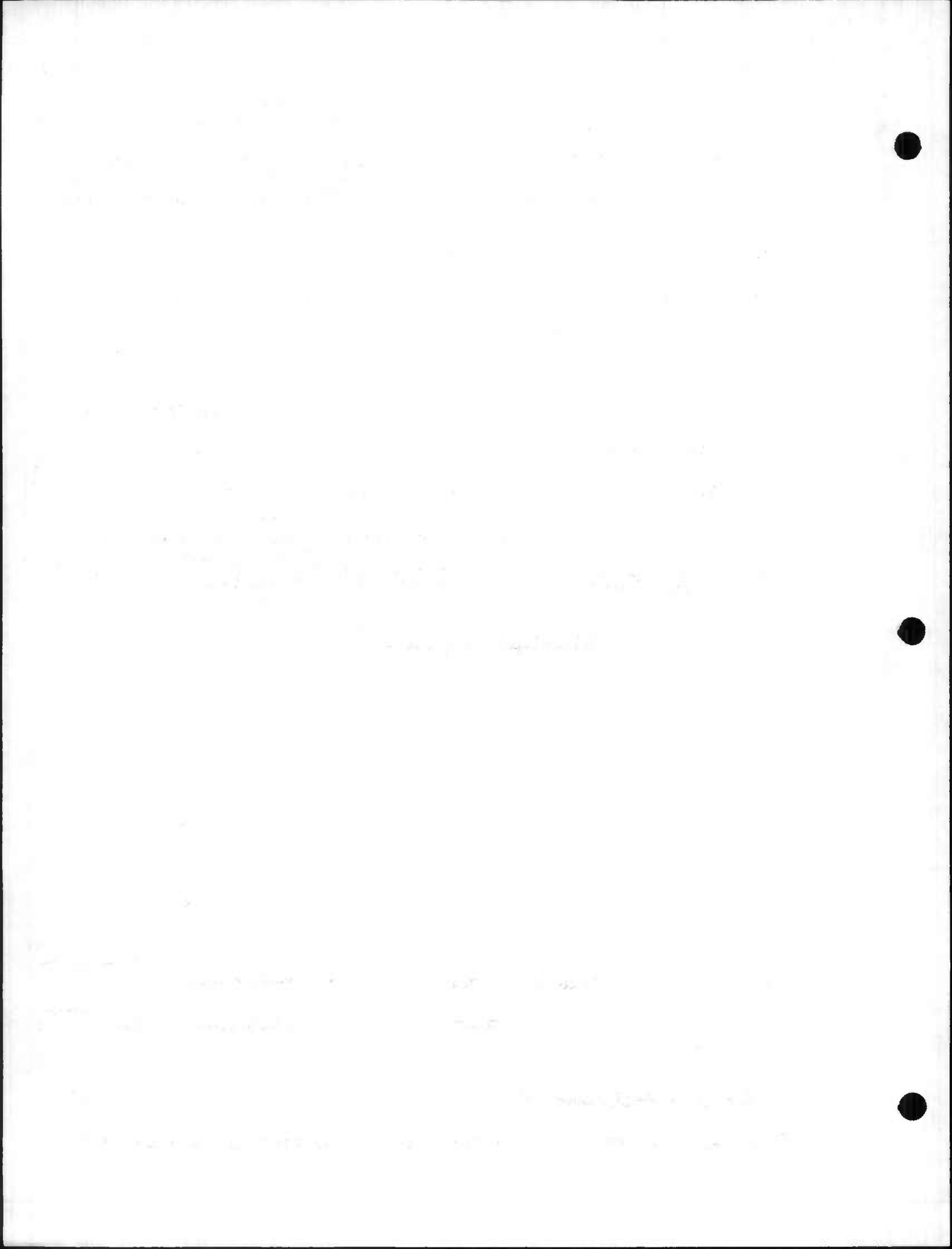
Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|--|---|--|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Josephine Godbold Havens | | | | 2. Date of Death Month JULY Day 26, Year 1997 | | | | 3. Time of Death 1:20PM | |
| | 4e. Facility Name (If not institution, give street and number) ROUTE#107 OFF ROUTE#28 WEST | | | | 4b. City, Town, or Location of Death POOLESVILLE | | | | 4c. County of Death MONTGOMERY | |
| Funeral Director | 5. Social Security Number 217-34-0081 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 92 Yrs. | | 8. Date of Birth (Month, Day, Year) April 19, 1905 | | 9. Birthplace (State or Foreign Country) California | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Cabin John | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number 6516 76th Place | | | | 10f. Zip Code 20818 | | 10g. Citizen of What Country? Montgomery | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 | | | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary | | | | 16b. Kind of Business/Industry American Red Cross | |
| | 17. Father's Name (First, Middle, Last) Charles Godbold | | | | 18. Mother's Name (First, Middle, Maiden Surname) Susan Not Available | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) William D. Havens / Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 124 Cedrow Avenue, Manteo, North Carolina 27954 | | | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc. | | | | Date July 29, 1997 | | 20c. Location - City or Town, State Bethesda, Maryland | |
| | 21. Signature of Funeral Service Licensee <i>Michael P. Kutta</i> M00348 | | | | 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc., 7557 Wisconsin Ave. Bethesda, Maryland 20814-3501 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <i>Multiple injuries</i> Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) ROADWAY | | | | | | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | | | | | | | |
| 28a. Date of Injury (Month, Day, Year) 7-26-97 | | | | | | | | | | |
| 28b. Time of Injury 1300 M | | | | | | | | | | |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 28d. Describe how injury occurred <i>Passenger in auto accident</i> | | | | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <i>street</i> | | | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) <i>Route 107 and 19501 White Ferry Road, Montgomery County</i> | | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier <i>Donald G. Wright MD</i> | | | | | | | | | | |
| 29c. License number O.C.M.E | | | | | | | | | | |
| 29d. Date signed (Month, Day, Year) JULY 27, 1997 | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DONALD G. WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 30 1997 | | | | | | | | | | |
| 32. Registrar's Signature <i>Julia Davidson-Randall</i> | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25318

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Barbara J. Harper

2. Date of Death

July 27, 1997

3. Time of Death

5:25 AM

Funeral
Director

4e. Facility Name (If not institution, give street and number)

Manor Care

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

577-52-6977

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

61

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Nov. 4, 1935

9. Birthplace (State or Foreign Country)

Georgia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

500 E. Melbourne Avenue

10f. Zip Code

20901

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Dietician

16b. Kind of Business/Industry

Health

17. Father's Name (First, Middle, Last)

Amaziah Hill

18. Mother's Name (First, Middle, Maiden Surname)

Susie Lee Johnson

19a. Informant's Name/Relationship (Type, Print)

Fred D. Harper

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

500 E. Melbourne Avenue Silver Spring, Maryland 20901

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Rock Creek Cemetery

Date

8/01/97

20c. Location - City or Town, State

Washington, D.C.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Coronary artery disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Diabetes mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D35336

29d. Date signed (Month, Day, Year)

7/29/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

10,810 Connecticut Ave. Kensington MD 20895

31. Date filed (Month, Day, Year)

JUL 31 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

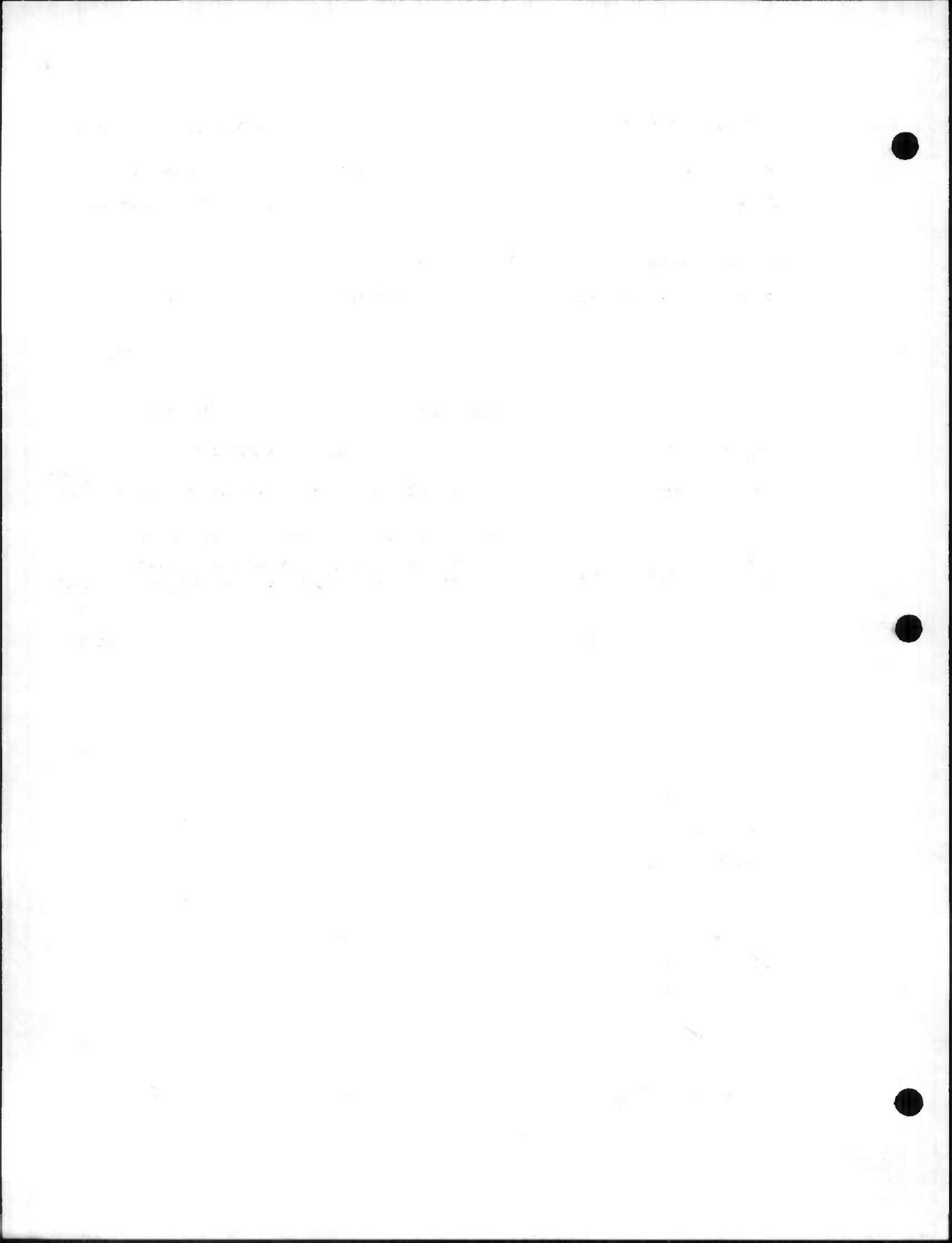
Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25319

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Helen M Hartman

2. Date of Death

Month Day Year
July 29 1997

3. Time of Death

1:40 pm

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Center Baltimore

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

723-14-6750

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
07-04-1927

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

GLEN BURNIE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

501 SARATOGA AVENUE

10f. Zip Code

21060

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

COPY EDITOR

16b. Kind of Business/Industry

MEDICAL JOURNALS

17. Father's Name (First, Middle, Last)

LUTHER FRANCIS VASA

MEYERS

18. Mother's Name (First, Middle, Maiden Surname)

EUGENIA LOUISE

CARRADO

19a. Informant's Name/Relationship (Type, Print)

ISAAC MYRL HARTMAN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

501 SARATOGA AVENUE, GLEN BURNIE, MD. 21060

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

GLEN HAVEN MEMORIAL PARK

Date

8/2/97

20c. Location - City or Town, State

GLEN BURNIE, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SINGLETON FUNERAL HOME,

1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

23a. Part I. Enter the disease or diseases that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

fungal peritonitis

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

1 week

b.

chronic peritoneal dialysis

Due to (or as a consequence of):

1 year

c.

end stage renal disease

Due to (or as a consequence of):

10 years

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

atrial fibrillation

congestive heart failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of causa
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Christopher G. Hall M.D.

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

July 29 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Christopher G. Hall, Tower 110, Johns Hopkins Hospital, Baltimore, MD 21205

31. Date filed (Month, Day, Year)

AUG 01 1997

32. Registrar's Signature

Julia Davidson-Pendall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

97-4157-510

B.K.S.

ROBERT HUNT JR,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25320

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | |
|--|---|--|---|--|--|-------------------------------|--|--|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Robert William Hunt, Jr. | | | | 2. Date of Death Month JULY Day 26, Year 1997 | | | | 3. Time of Death 7:34AM | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) UNIVERSITY HOSPITAL S.T.U | | | | 4b. City, Town, or Location of Death BALTIMORE | | | | 4c. County of Death n/a | | | | | | |
| Funeral Director | 5. Social Security Number 214-02-8504 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 30 Yrs. | | 8. Date of Birth (Month, Day, Year) April 24, 1967 | | 9. Birthplace (State or Foreign Country) Pennsylvania | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Anne Arundel | | 10c. City, Town or Location Arnold | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| | 10e. Street and Number 853 Shore Acres Road | | | | 10f. Zip Code 21012 | | 10g. Citizen of What Country? USA | | | | | | | | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4or 5+) 12 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Roofing | | | 16b. Kind of Business/Industry Roofing | | | | | | | |
| | 17. Father's Name (First, Middle, Last) Robert W. Hunt, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname) Ethel B. Hammond | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Robert Hunt, Sr./Father | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 853 Shore Acres Rd., Arnold, MD 21012 | | | | | | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Woodbury Memorial Park | | Data Aug 1 1997 | | 20c. Location - City or Town, State West Deptford, NJ | | | | | | | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146 | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple injuries Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| | | | | | | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) 7-26-97 | | 28b. Time of Injury 0622 M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred Driver of car struck pole | | | | | |
| | | | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Street | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) Jones Station Road, Anne Arundel Co. | | | | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | 29b. Signature and title of certifier | | 29c. License number O. C. M. E. | | 29d. Date signed (Month, Day, Year) JULY 27, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DONALD G. WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 31 1997 | | | | 32. Registrar's Signature | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar


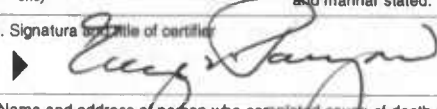
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25321

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) George Edwin Howard III | | | | 2. Date of Death Month August Day 1 Year 1997 | | 3. Time of Death 2:00 AM | |
| | 4a. Facility Name (If not institution, give street and number) Chesapeake Hospice House | | | | 4b. City, Town, or Location of Death Linthicum | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 175-26-9891 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 63 Yrs. | | 8. Date of Birth (Month, Day, Year) Jan 3 1934 | |
| | 9. Birthplace (State or Foreign Country) Washington, D.C. | | 10a. State n/a | | 10b. County n/a | | 10c. City, Town or Location Washington, D.C. | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 1367 Morris Road, S.E. | | 10f. Zip Code 20020 | | 10g. Citizen of What Country? United States | |
| | 11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrical Engineer | | 16b. Kind of Business/Industry Electrical | | 17. Father's Name (First, Middle, Last) George Edwin Howard, Jr. | |
| | 18. Mother's Name (First, Middle, Maiden Surname) Margaret B. Boyd | | 19a. Informant's Name/Relationship (Type, Print) Chalmers Howard (Brother) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4402 Lancaster Street Harrisburg, Pennsylvania 17111 | | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Crematory Aug 15 1997 Brentwood, Maryland | | 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cancer of Lung. Due to (or as a consequence of): Small Cell Carcinoma. | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) M | | 28b. Time of Injury M | |
| | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and Title of certifier  | | 29c. License number 142955 | | 29d. Date signed (Month, Day, Year) 8/1/97 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1328 Southern Ave SE Suite 210 Washington, DC 20032 | |
| | 31. Date filed (Month, Day, Year) AUG 06 1997 | | 32. Registrar's Signature  | | 33. State Registrar | | 34. State Registrar | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25322

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Walter Howard

2. Date of Death

Month
08Day
03Year
97

3. Time of Death

10:30 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Gladys Spelman Nursing Home

4b. City, Town, or Location of Death

Cheverly, Md.

4c. County of Death

Prince Georges

5. Social Security Number

579-14-0140

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Aug. 23, 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

DC

10b. County

None

10c. City, Town or Location

Washington, D.C.

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1516 Ridge Place, S.E.

10f. Zip Code

20020

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

6th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Peter Howard

18. Mother's Name (First, Middle, Maiden Surname)

Ida Scott

19a. Informant's Name/Relationship (Type, Print)

Anna Proctor (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1516 Ridge Pl., SE; Washington, DC 20020

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Olivet Cemetery

Date

08/09/97

20c. Location - City or Town, State

Washington, DC

21. Signature of Funeral Service Licensee

Ralph Williams

22. Name and Address of Facility

Ralph Williams Funeral Service

517 - 11th Street, SE; Wash., DC

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE

Due to (or as a consequence of):

b. Multiple strokes.

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

> 2-wks.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal insufficiency.

HTN.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

S. J. Rao

29c. License number

D-34525

29d. Date signed (Month, Day, Year)

08-05-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

S. J. Rao, MD; 4000 - Mitchellville Road; #220; Bowie - MD - 20716

31. Date filed (Month, Day, Year)

AUG 07 1997

32. Registrar's Signature

John Anderson-Rodall

State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25323

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Robert B. Harding

2. Date of Death

Month Day Year
August 5, 1997

3. Time of Death

4:25 am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

579-24-8556

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

July 26, 1927

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1003 Strout Street

10f. Zip Code

20901

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

Collage (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Contractor

16b. Kind of Business/Industry

R.B. Harding
Contractors

17. Father's Name (First, Middle, Last)

Clarence Richardson Harding

18. Mother's Name (First, Middle, Maiden Surname)

Gertrude Louise Bradley

19a. Informant's Name/Relationship (Type, Print)

Robert B. Harding, Jr. - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7906 Carriage Drive, Severn, Maryland 21114

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

08/07/97

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

► Claudette L. Gasch

22. Name and Address of Facility

Francis Gasch's Sons Funeral Home, P.A.

4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

CARDIOGENIC SHOCK

Due to (or as a consequence of):

b.

CORONARY DISEASE

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

VENTRICULAR TACHYCARDIA

MITRAL REGURGITATION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► [Signature]

29c. License number

D24819

29d. Date signed (Month, Day, Year)

8/5/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Zinsmeister 8830 Cameron Street, Silver Spring, Maryland

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

John [Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25324

Amend # 11, 20b 8/4/97 cms AACO Health Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

| | | | | | | | |
|---|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last) MARK Anthony Hopkins | | | | 2. Date of Death Month July Day 26 Year 97 | | 3. Time of Death 0704 | |
| 4a. Facility Name (If not institution, give street and number) Anne Arundel Gen Hosp | | | | 4b. City, Town, or Location of Death Annapolis | | 4c. County of Death AA | |
| 5. Social Security Number 220-84-3354 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 32 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Sept 2, 1964 | |
| 9. Birthplace (State or Foreign Country) Maryland | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County Anne Arundel | | 10c. City, Town or Location Arnold | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 128 Shore Road | | | | 10f. Zip Code 21012 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Construction | | 16b. Kind of Business/Industry Construction | |
| 17. Father's Name (First, Middle, Last) James Michael Hopkins | | | | 18. Mother's Name (First, Middle, Maiden Surname) Monica Sade | | | |
| 19a. Informant's Name/Relationship (Type, Print) Monica Sade/mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 716 Magothy Road, Arnold, MD 21012 | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory | | Date 7/31/97 8-31-97 | | 20c. Location - City or Town, State Baltimore, MD | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146 | | | |

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|---|--|--|--|---|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Trauma Due to (or as a consequence of): b. Motor Vehicle Accident Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | Approximate Interval Between Onset and Death minutes | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 7/26/97 | | 28b. Time of Injury 0622M | |
| | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred Car hit pole | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Street | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) Arnold, MD. | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier Deputy | | 29c. License number D 06054 | | 29d. Date signed (Month, Day, Year) 7/26/97 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William P. Jones, MD 695 America 21035 | | | | | |

State
Registrar

JUL 31 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25325

Certificate of Death

Reg. No.

| | | | | | | | |
|--|---|--|---|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Pang Cha James | | | 2. Date of Death Month Day Year August 3 1997 | | 3. Time of Death 1354 | |
| | 4e. Facility Name (If not institution, give street and number) Fallston General Hospital | | | 4b. City, Town, or Location of Death Fallston | | 4c. County of Death Harford | |
| Funeral Director | 5. Social Security Number 216-66-9646 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 53 Yrs. | | 8. Date of Birth (Month, Day, Year) Dec. 28, 1943 |
| | 10a. State Maryland | | 10b. County Harford | | 10c. City, Town or Location Bel Air | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| To Be Completed by Funeral Director | 10e. Street and Number 1402 Coventry Court | | | 10f. Zip Code 21014 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Korean |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machine Operator | | 16b. Kind of Business/Industry Manufacturing | | |
| | 17. Father's Name (First, Middle, Last) Kwisam (nmn) Yang | | | 18. Mother's Name (First, Middle, Maiden Surname) Jin (nmn) Park | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Kenneth G. James - Husband | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1402 Coventry Ct., Bel Air, MD 21014 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Highview Memorial Gardens 8-7-97 | | 20c. Location - City or Town, State Fallston, Maryland | | |
| | 21. Signature of Funeral Service Licensee <i>Howard K. McComas III</i> | | 22. Name and Address of Facility Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Massive Intracranial Hemorrhage 4 hours Due to (or as a consequence of): b. Hypertension Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28e. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | |
| | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | |
| State Registrar | 29b. Signature and title of certifier <i>J. Douglas Abbott</i> | | | 29c. License number D23446 | | 29d. Date signed (Month, Day, Year) August 3, 1997 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>J. Douglas Abbott Suite 104 1216 Harford Rd Fallston Md 21037</i> | | | | | | |
| | 31. Date filed (Month, Day, Year) AUG 5 1997 | | | 32. Registrar's Signature <i>J. Douglas Abbott</i> | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

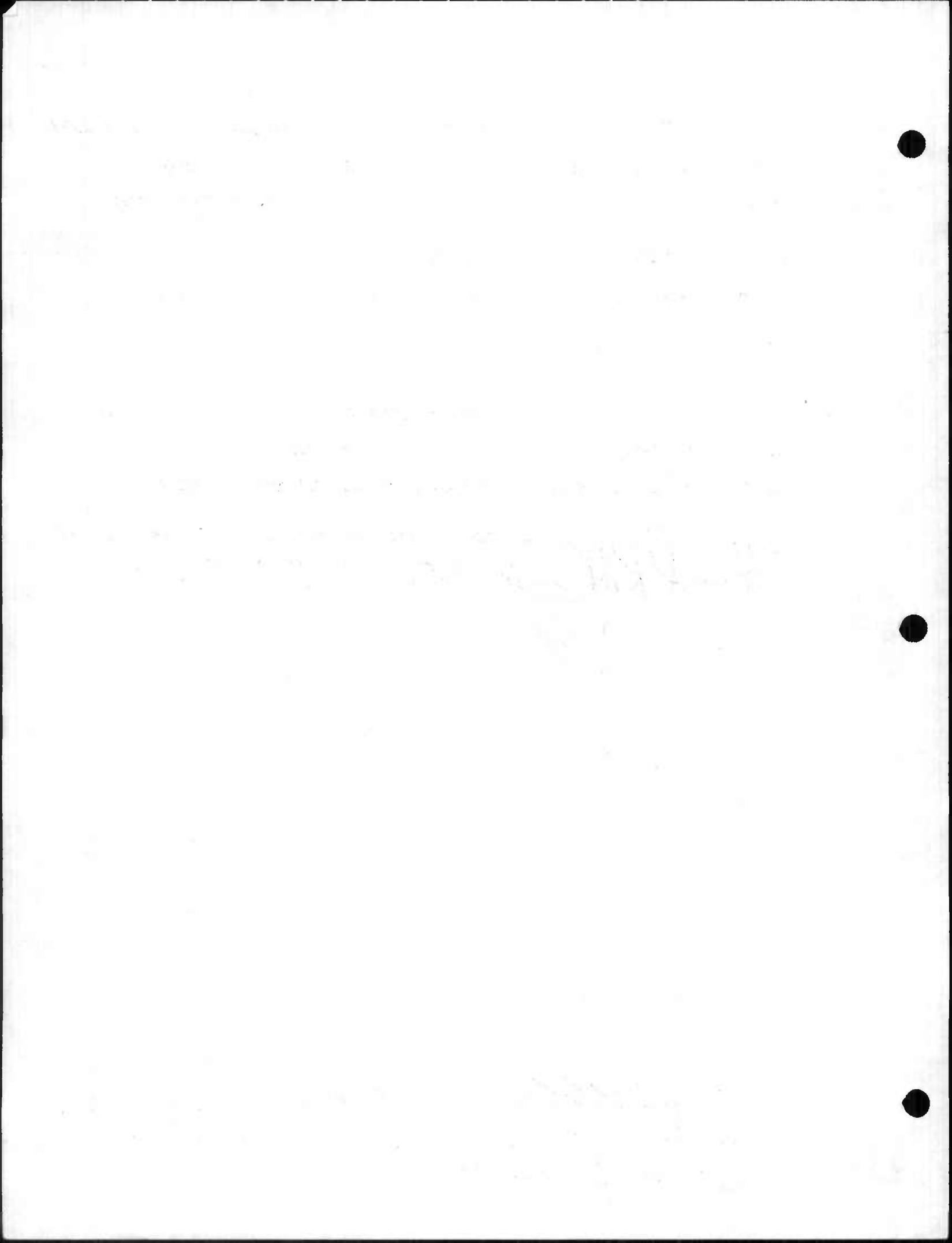
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25326

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

KAMAL HARISH JAIN

2. Date of Death

Month Day Year
July 30 1997

3. Time of Death

12:55 pm

4a. Facility Name (If not institution, give street and number)

18800 Impulse Lane

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

156-52-1989

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

60 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 6, 1937

9. Birthplace (State or Foreign Country)

India

Usual Residence of Decedent

10a. State

Md.

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

18800 Impulse Lane

10f. Zip Code

20879

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Asian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Motilal

Bhalgat

18. Mother's Name (First, Middle, Maiden Surname)

Suvabai

Mutha

19a. Informant's Name/Relationship (Type, Print)

Harish Kumar Jain (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18800 Impulse La. Gaithersburg, Md. 20879

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

July 31, 1997

20c. Location - City or Town, State

Alexandria, Va.

21. Signature of Funeral Service Licensee

Michael D. Gelber

22. Name and Address of Facility

DeVol Funeral Home
10 East Deer Park Dr. Gaithersburg, Md. 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. metastatic pancreatic cancer
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 1/2 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

George A. Sidor

29c. License number

43083

29d. Date signed (Month, Day, Year)

July 30, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

7707 medical center drive #300 Rockville MD 20850

31. Date filed (Month, Day, Year)

AUG 01 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

97 25327

Certificate of Death

Reg. No.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

DHHM 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25328

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ISAIAH M. JOHNSON

2. Date of Death
Month Day Year

7 29 97

3. Time of Death

1945

4a. Facility Name (If not institution, give street and number)

ANNE ARUNDEL MEDICAL CENTER

4b. City, Town, or Location of Death

ANNAPOLIS

4c. County of Death

ANNE ARUNDEL

Funeral
Director

5. Social Security Number

214-05-2117

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

MAY 4 1913

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

ANNAPOLIS

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

344 FOREST BEACH ROAD

10f. Zip Code

21401

10g. Citizen of What Country?

US

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3rd

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SELF EMPLOYED

16b. Kind of Business/Industry

SANITATION

17. Father's Name (First, Middle, Last)

WILL JOHNSON

18. Mother's Name (First, Middle, Maiden Surname)

CARRIE STANSBURY

19a. Informant's Name/Relationship (Type, Print)

MICHAEL JOHNSON (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7908 NEW FREETOWN RD. PASADENA, MD. 21122

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ASBURY BROADNECK CEMETERY

Date

8/2/87

20c. Location - City or Town, State

ST. MARGARETS, MD.

21. Signature of Funeral Service Licensee

Lam B. Reese

22. Name and Address of Facility

WM. REESE & SONS MORTUARY, P.A.

821 WEST ST. ANNAPOLIS, MD. 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

MYOCARDIAL INFARCTION

Approximate Interval Between Onset and Death

1 HR

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

DUE TO (or as a consequence of): ATRIAL FIBRILLATION

DUE TO (or as a consequence of): HYPERTENSION

DUE TO (or as a consequence of):

3 MTH

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CARCINOMA OF PROSTATE WITH METASTASES
IDDM

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Donald C. Roane, M.D.

29c. License number

D00698

29d. Date signed (Month, Day, Year)

July 30, 1997

30. Name and address of person who completed cause of death (item 23e) (Type, Print)

Donald C. Roane, M.D. 1616 FOREST DRIVE ANNAPOLIS 21403

State
Registrar

31. Date filed (Month, Day, Year)

AUG 04 1997

32. Registrar's Signature

Julia Davidson-Rendell

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

97-4321-033

B.K.S

UNK. 97-169

CARVEL T. JONES

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25329

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Carvel T. Jones, Jr. | | | | 2. Date of Death Month Day Year AUG. 03, 1997 | | 3. Time of Death 11:27PM | |
| | 4a. Facility Name (If not institution, give street and number) 4316 RANGER AVENUE | | | | 4b. City, Town, or Location of Death TEMPLE HILLS | | 4c. County of Death PRINCE GEORGES | |
| Funeral Director | 5. Social Security Number 215-09-1549 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 20 Yrs. | | 8. Date of Birth (Month, Day, Year) 1/29/77 | |
| | 9. Birthplace (State or Foreign Country) Wash., D.C. | | 10a. State Md. | | 10b. County P.G. | | 10c. City, Town or Location Glenarden | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 8618 McLain Ave. | | 10f. Zip Code 20706 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Unemployed | | 16b. Kind of Business/Industry None | | | |
| | 17. Father's Name (First, Middle, Last) Carvel T. Jones, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname) Sandra Phillips | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Sandra Jones/Mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4217 28th Ave., Temple Hills, Md. 20747 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Mem. Park | | 20c. Date 8/11/97 | | 20d. Location - City or Town, State Landover, Md. | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility H.S. Washington & Sons, Inc. 4925 Burroughs Ave., N.E. | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. GUNSHOT WOUND OF HEAD Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| Physician /Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 28a. Date of Injury (Month, Day, Year) 8-3-97 | | 28b. Time of Injury UNK. M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred SUBJECT SHOT | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) STREET | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4316 RANGER AVENUE, TEMPLE HILLS MD. | | | | | |
| | 29a. Certifier (Check one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| | 29b. Signature and title of certifier | | 29c. License number O.C.M.E | | 29d. Date signed (Month, Day, Year) AUG. 4, 1997 | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| | 31. Date filed (Month, Day, Year) AUG 07 1997 | | 32. Registrar's Signature | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25330

Certificate of Death

Reg. No.

| | | | | | | | | | | | | |
|--|---|--|---|--|--|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Ada M. Jenkins | | | | 2. Date of Death Month Day Year August 1, 1997 | | | | 3. Time of Death 8:25 am | | | |
| | 4e. Facility Name (If not institution, give street and number) Prince George's Hospital Center | | | | 4b. City, Town, or Location of Death Cheverly | | | | 4c. County of Death Prince George's | | | |
| Funeral Director | 5. Social Security Number 579-28-5404 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 71 Yrs. | | 8. Date of Birth (Month, Day, Year) March 24, 1926 | | 9. Birthplace (State or Foreign Country) Maryland | | | |
| | Usual Residence of Decedent | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Prince George's | | 10c. City, Town or Location Upper Marlboro | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | 10e. Street and Number 9111 Columbine Lane | | | | 10f. Zip Code 20772 | | | | 10g. Citizen of What Country? U.S.A. | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Claims Examiner | | | | 16b. Kind of Business/Industry Treasury Department | | | |
| | 17. Father's Name (First, Middle, Last) Harry E. Davis | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary E. Zigler | | | | | | | |
| | 19e. Informant's Name/Relationship (Type, Print) Carol A. Grooms - Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9102 Marrellas Drive, Owings, Maryland 20736 | | | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Carmel Cemetery | | Date 8/4/97 | | 20c. Location - City or Town, State Sunshine, Maryland | | | | | |
| | 21. Signature of Funeral Service Licensee Claudette J. Gasch | | | | 22. Name and Address of Facility Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Heart Failure Due to (or as a consequence of): b. Arrhythmia Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Encephalopathy, cerebral | | | | | | | | | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | |
| | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Dennis M. Hall | | 29c. License number D41216 | | 29d. Date signed (Month, Day, Year) 8-2-97 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis M. Hall MD 1204 W. St. Annapolis, MD | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 04: 1997 | | | | | | | | | | | | |
| 32. Registrar's Signature John Anderson-Rodell | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

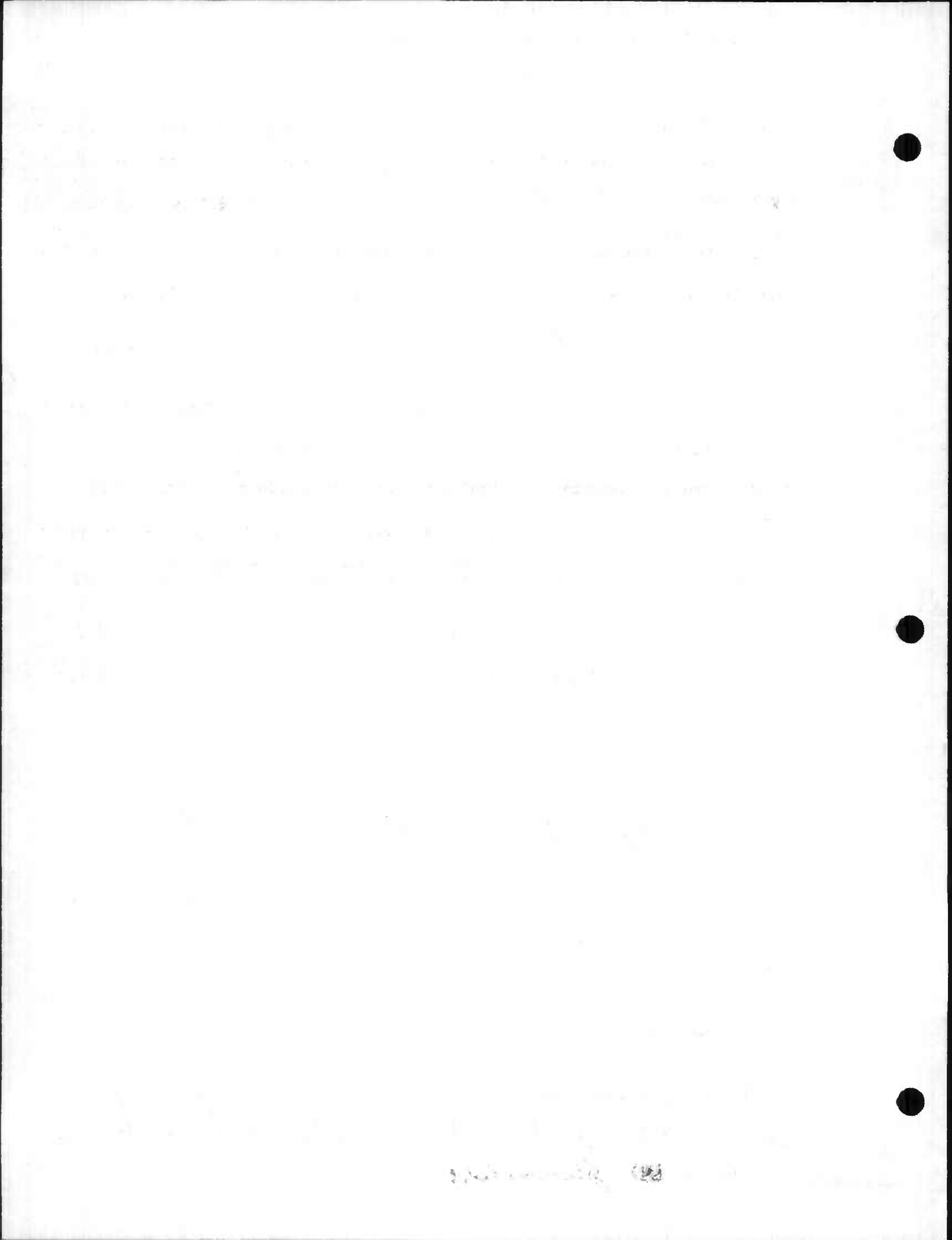
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25331

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ANNA KARIN JOHNSON

2. Date of Death

Month Day Year
JULY 29, 1997

3. Time of Death

7:15 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

NATIONAL LUTHERAN HOME

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY CO.

5. Social Security Number

262-62-6892

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

97

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
MAY 23, 1900

9. Birthplace (State or Foreign Country)

SWEDEN

Usual Residence of Decedent

10a. State

MD.

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

199 ROLLINS AVENUE

10f. Zip Code

20852

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

GUIDE

16b. Kind of Business/Industry

DECATUR HOUSE

17. Father's Name (First, Middle, Last)

JOHAN A. ANDERSON

18. Mother's Name (First, Middle, Maiden Surname)

HANNA ERICKSON

19a. Informant's Name/Relationship (Type, Print)

REV. DR. REICHARD

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9701-VEIRS DR., ROCKVILLE, MD. 20850

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

ROCK CREEK CEMETERY-8/4/97

Date

20c. Location - City or Town, State

WASHINGTON, DC

21. Signature of Funeral Service Licensee

W.M. Hyson

22. Name and Address of Facility

HYSONG CO., INC. 1300-N ST., NW

WASHINGTON, DC

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimers

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Daniel A. Jaller

29c. License number

D33138

29d. Date signed (Month, Day, Year)

July 29, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Daniel A. Jaller

12850 Middlebrook Rd. Germantown, MD.

31. Date filed (Month, Day, Year)

AUG 04 1997

32. Registrar's Signature

John Anderson Parrott

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

x

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25332

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Evelyn H. Jenkins | | | | 2. Date of Death Month July Day 31 Year 1997 | | 3. Time of Death 9:45 AM | |
| | 4a. Facility Name (If not institution, give street and number) Doctor's Hospital | | | | 4b. City, Town, or Location of Death Lanham | | 4c. County of Death Prince George's | |
| Funeral Director | 5. Social Security Number 237-62-3349 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 57 Yrs. | | 8. Date of Birth (Month, Day, Year) 04-08-40 | |
| | 9. Birthplace (State or Foreign Country) North Carolina | | 10a. State Maryland | | 10b. County Prince George's | | 10c. City, Town or Location Lanham | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 10e. Street and Number 9205 Roxanne Drive | | 10f. Zip Code 20706 | |
| | 10g. Citizen of What Country? USA | | | | 11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+) | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) School Librarian | | | | 16b. Kind of Business/Industry Government | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Harry Hall | | | | 18. Mother's Name (First, Middle, Maiden Summa) Elizabeth Garrett | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Theodore Jenkins Jr./Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9205 Roxanne Drive, Lanham, Maryland 20706 | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Toodle's Cemetery | | 20c. Location - City or Town, State 8/7/97 Plymouth, NC | |
| | 21. Signature of Funeral Service Licensee Nancy A. Perentie | | | | 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road, Landover, Maryland 20785 | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Lung Cancer Due to (or as a consequence of): CARDIO PULMONARY ARREST Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last UNKNOWN | | | | Approximate Interval Between Onset and Death | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 28d. Describe how injury occurred | | | |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier Steven Bentman MD | | | |
| To Be Completed by Physician/Medical Examiner | 29c. License number 036487 | | | | 29d. Date signed (Month, Day, Year) 7/31/97 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEVEN BENTMAN, MD 375 MAIN STREET, SUITE 305, LAUREL, MD 20707 | | | | 31. Date filed (Month, Day, Year) AUG 05 1997 | | | |
| To Be Completed by Physician/Medical Examiner | 32. Registrar's Signature John Davidson-Randall | | | | 33. Date of Death 97 25332 | | | |
| | 34. Date of Death 97 25332 | | | | 35. Date of Death 97 25332 | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25333

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

FRANCIS HAROLD JACKSON

2. Date of Death

Month August 1, 1997 Year

3. Time of Death

6:10 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Greenbelt Nursing Center

4b. City, Town, or Location of Death

Greenbelt

4c. County of Death

Prince Georges

5. Social Security Number

217-14-7724

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

79

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 28, 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Riverdale

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

6215 44th Avenue

10f. Zip Code

20737

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☒ Yes ☐ No WW II
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
White15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

0

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Stationary Engineer

16b. Kind of Business/Industry

University of Maryland

17. Father's Name (First, Middle, Last)

James E. Jackson

18. Mother's Name (First, Middle, Maiden Surname)

Alice M. King

19a. Informant's Name/Relationship (Type, Print)

Mary Jane Jackson-Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6215 44th Avenue, Riverdale, Maryland 20737

20a. Method of Disposition

☐ Burial ☐ Cremation ☐ Removal from State
☒ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)George Washington University Medical
Center

Date

August 1, 1997

20c. Location - City or Town, State

Washington, DC

21. Signature of Funeral Service Licensee

Plutaco Rindan

22. Name and Address of Facility

Columbia Mortuary Services, Inc.
25 Missouri Ave., NW, Washington, DC 2001123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. ASPIRATION PNEUMONIA
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

3 months

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

John M. O'Donoghue MD

29c. License number

20391

29d. Date signed (Month, Day, Year)

August 1, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR JEFFREY KELMAN, 6525 BELCREST ROAD, HYATTSVILLE, MD 20782

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

John M. O'Donoghue

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25334

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|--|--|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MILDRED J JACKSON | | | | 2. Date of Death Month AUGUST Day 2 Year 1997 | | 3. Time of Death 4:00PM | |
| | 4a. Facility Name (If not institution, give street and number) 609 PRITCHARD LANE | | | | 4b. City, Town, or Location of Death LARGO MD | | 4c. County of Death PRINCE GEORGES | |
| Funeral Director | 5. Social Security Number 057 20 2520 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 71 Yrs. | | 8. Date of Birth (Month, Day, Year) MAY 2 1926 | |
| | 9. Birthplace (State or Foreign Country) U.S.A. VIRGINIA | | 10a. State VA. | | 10b. County GREENSVILLE | | 10c. City, Town or Location SKIPERS | |
| 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 5100 FIDDLERS ROAD | | 10f. Zip Code 23847 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Collage (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEWIFE | | 16b. Kind of Business/Industry DOMESTIC | | 17. Father's Name (First, Middle, Last) ZOLLIE WRIGHT | | |
| 18. Mother's Name (First, Middle, Maiden Surname) EULAR MILES | | 19a. Informant's Name/Relationship (Type, Print) RUSSELL JACKSON (HUSBAND) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5100 FIDDLERS ROAD GREENVILLE VA | | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place) ANTIOCH CHURCH CEMETERY | | 20c. Location - City or Town, State GREENVILLE VA. | | 20d. Date 8/7/97 | | 21. Signature of Funeral Service Licensee <i>Alex Pope Jr</i> MO0859 | | |
| 22. Name and Address of Facility POPE FUNERAL HOMES 5538 MARLBORO PIKE MD. 20747 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. METASTATIC CARCINOMA OF THE COLON | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | |
| 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>Cynthia Woodson</i> | | |
| 29c. License number D 36958 | | 29d. Date signed (Month, Day, Year) 8/5/97 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CYNTHIA WOODSON MD 1400 MERCANTILE LN DU 230 LARGO MD 20774 | | 31. Date filed (Month, Day, Year) AUG 08 1997 | | |
| 32. Registrar's Signature <i>John D. ...</i> | | 33. State Registrar State Registrar | | 34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | | 35. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

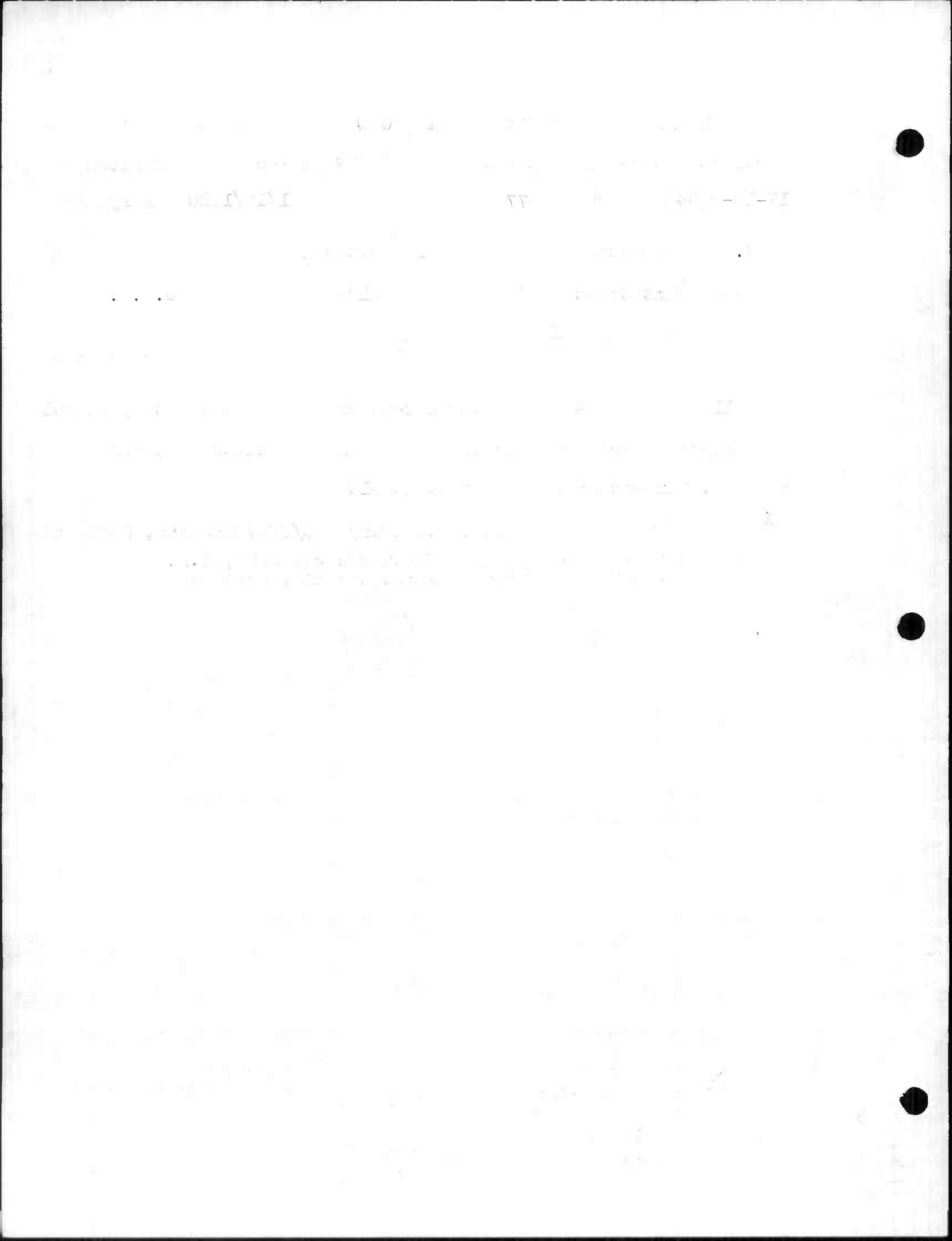
State of Maryland / Department of Health and Mental Hygiene

97 25335

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) LUELLA KENLY KIRKWOOD | | | | 2. Date of Death Month JULY Day 30 Year 1997 | | 3. Time of Death 1435 | |
| | 4a. Facility Name (If not institution, give street and number) Fallston General Hospital | | | | 4b. City, Town, or Location of Death Fallston | | 4c. County of Death Harford | |
| Funeral Director | 5. Social Security Number 217-18-0964 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 77 Yrs. | | 8. Date of Birth (Month, Day, Year) 1/10/1920 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10e. State Md. | | 10b. County Harford | | 10c. City, Town or Location Jarrettsville | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 4043 Hunt Crest Road | | 10f. Zip Code 21084 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Caucasian | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 4 | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) School Teacher | | 16b. Kind of Business/Industry Elementary School | | | |
| | 17. Father's Name (First, Middle, Last) Charles Sherwood Kenly | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Ellen Nelson | | | |
| To Be Completed by Physician/Medical Examiner | 19. Informant's Name/Relationship (Type, Print) Barry N. Kirkwood/Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as #10 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Bethel Cemetery | | 20c. Location - City or Town, State 8/2/97 Madonna, Maryland | | | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Kurtz Funeral Home, P.A. Jarrettsville, Maryland | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CARDIOGENIC SHOCK Due to (or as a consequence of): b. ACUTE INFERIOR MYOCARDIAL INFARCTION Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death 60 MINUTES 1 DAY | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COMPLETE HEART BLOCK | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier  | | 29c. License number D16036 | |
| | 29d. Date signed (Month, Day, Year) July 30, 1997 | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dean L. Vasser | | | | | | | |
| | 31. Date filed (Month, Day, Year) AUG 4 1997 | | | | 32. Registrar's Signature  | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25336

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Kenneth Lamar Keister

2. Date of Death

Month
Aug.Day
8Year
1997

3. Time of Death

6:15 PM

4a. Facility Name (If not institution, give street and number)

Harford Memorial Hospital

4b. City, Town, or Location of Death

Havre de Grace

4c. County of Death

Harford

5. Social Security Number

167-30-6617

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

59 Yrs.

8. Date of Birth

Month
DecemberDay
18Year
1937

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Elkton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1950 Old Elk Neck Road

10f. Zip Code

21921

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: US Army 1957

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Electrician

16b. Kind of Business/Industry

Building Maintenance

17. Father's Name (First, Middle, Last)

Foster Keister

18. Mother's Name (First, Middle, Maiden Surname)

Alma Strawhecker

19a. Informant's Name/Relationship (Type, Print)

Jean Stratton-Keister/Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1950 Old Elk Neck Road, Elkton, MD 21921

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

R.A. Ferris Crematory

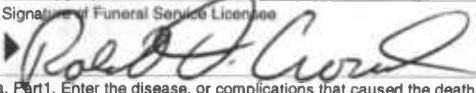
Date

Aug. 12 1997

20c. Location - City or Town, State

West Chester Pennsylvania

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Crouch Funeral Home
127 South Main Street, North East, MD 21901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Bilateral Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 week

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Septic shock syndrome

Due to (or as a consequence of):

1 day

c. Multi organ system failure.

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

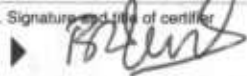
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

D18424

29d. Date signed (Month, Day, Year)

Aug. 8 - 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

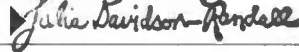
B.D. PAREKH MD. 1908 HARFORD ROAD FAULSTON MD. 21047.

State
Registrar

31. Date filed (Month, Day, Year)

AUG 11 1997

32. Registrar's Signature



Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

4+1/1A

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25337

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|---|--|--|--|--|--|---|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) William Henry Koehler | | | | | | 2. Date of Death Month Day Year July 29, 1997 | | 3. Time of Death 7:10 AM | |
| | 4a. Facility Name (If not Institution, give street and number) 1812 Alcan Drive | | | | | | 4b. City, Town, or Location of Death Silver Spring | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 578-12-8557 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 79 Yrs. | | 8. Date of Birth (Month, Day, Year) Nov. 6, 1917 | | 9. Birthplace (State or Foreign Country) Washington, D.C. | |
| | Usual Residence of Decedent | | | | | | 10a. State Maryland | | 10b. County Montgomery | |
| To Be Completed by Funeral Director | 10c. City, Town or Location Silver Spring | | | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 1812 Alcan Drive | |
| | 10f. Zip Code 20902 | | | | | | 10g. Citizen of What Country? U.S.A | | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II | | | | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) | | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bus Driver | | 16b. Kind of Business/Industry Transportation | |
| | 17. Father's Name (First, Middle, Last) Harry Koehler | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Sadie Peacock | | 19a. Informant's Name/Relationship (Type, Print) Silvia G. Balderas-Saari | |
| | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1711 Dublin Drive Silver Spring, Maryland 20902 | | | | | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Quantico National Cemetery | |
| | 20c. Location - City or Town, State Quantico, Virginia | | | | | | 21. Signature of Funeral Service Licensee <i>Ancheu Cole</i> | | 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Immediate Cause (Final disease or condition resulting in death) a. renal failure Due to (or as a consequence of): b. multiple myeloma Due to (or as a consequence of): c. Parkinson's disease Due to (or as a consequence of): d. | | | | | | Approximate Interval Between Onset and Death 4 days months years | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of injury M | | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>G. Nicholas Rogentine, Jr.</i> | | |
| 29c. License number D22854 | | | | | | 29d. Date signed (Month, Day, Year) July 30, 1997 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) G. Nicholas Rogentine, Jr., M.D. 10810 Connecticut Avenue Kensington, MD 20895 | | |
| 31. Date filed (Month, Day, Year) JUL 31 1997 | | | | | | 32. Registrar's Signature <i>Julia Davidson-Rendell</i> | | State Registrar | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25338

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LILLIE MAY KLOTZ

2. Date of Death

Month JULY Day 25, Year 1997

3. Time of Death

7:00 PM

4e. Facility Name (If not institution, give street and number)

9801 TRIBONIAN DR.

4b. City, Town, or Location of Death

FT. WASHINGTON

4c. County of Death

PRINCE GEORGES

5. Social Security Number

577-38-2586

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
DEC. 17, 1914

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD.

10b. County

PRINCE GEORGES

10c. City, Town or Location

FT. WASHINGTON

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

9801 TRIBONIAN DR.

10f. Zip Code

20744

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

AT HOME

17. Father's Name (First, Middle, Last)

CHARLES JOSEPH PARISH

18. Mother's Name (First, Middle, Maiden Surname)

LILLIE MAY TUBBS

19a. Informant's Name/Relationship (Type, Print)

CHARLES R. KLOTZ/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

SAME AS ITEM #10

20e. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHAMBERS CREMATORY

Date

7/31/97

20c. Location - City or Town, State

RIVERDALE, MD.

21. Signature of Funeral Service Licensee

W.W. Chambers M00091

22. Name and Address of Facility

CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737

23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

4 yrs.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

D.J. Haidak

29c. License number

D 17605

29d. Date signed (Month, Day, Year)

7/26/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D.J. Haidak MD 8926 WOODYARD Rd. #201, CLINTON, Md.

31. Date filed (Month, Day, Year)

JUL 30 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

100 300 1000 2000 3000 4000 5000 6000 7000 8000 9000 10000

100 300 1000 2000 3000 4000 5000 6000 7000 8000 9000 10000

100 300 1000 2000 3000 4000 5000 6000 7000 8000 9000 10000

100 300 1000 2000 3000 4000 5000 6000 7000 8000 9000 10000

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100 300 1000 2000 3000 4000 5000 6000 7000 8000 9000 10000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25339

Certificate of Death

Reg. No.

| | | | | | | | |
|---|--|--|---|---|--|-----------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Jeffrey R. Klaess | | | 2. Date of Death Month Day Year 07 26 97 | | 3. Time of Death 2:10 pm | |
| | 4e. Facility Name (If not institution, give street and number) Washington Adventist Hospital | | | 4b. City, Town, or Location of Death Takoma Park | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 579-48-3356 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 62 Yrs. | | 8. Date of Birth (Month, Day, Year) July 27, 1934 |
| | Usual Residence of Decedent | | 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Silver Spring |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 15217 Watergate Road | | 10f. Zip Code 20905 | | 10g. Citizen of What Country? United States |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpet Estimator | | 16b. Kind of Business/Industry Carpeting | | |
| | 17. Father's Name (First, Middle, Last) John William Klaess | | | 18. Mother's Name (First, Middle, Maiden Surname) Alyce Warfield | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Barbara A. Klaess | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as 10 | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory | | 20c. Location - City or Town, State 7-27-97 Beltsville, Maryland | | |
| | 21. Signature of Funeral Service Licensee Eileen H. Rapp | | 22. Name and Address of Facility Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pulmonary embolism Due to (or as a consequence of): b. Respiratory failure Due to (or as a consequence of): c. Adenocarcinoma right lower lobe Due to (or as a consequence of): d. { | | | | | | |
| | 23b. Approximate Interval Between Onset and Death 2-3 hrs 5 weeks 8-12 months | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. - Pulmonary fibrosis - right lower lobectomy - myocardial infarction | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | | | |
| | 28a. Date of Injury (Month, Day, Year) | | | | | | |
| | 28b. Time of Injury M | | | | | | |
| | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| | 28d. Describe how injury occurred | | | | | | |
| 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier Jaime F. Marquez, M.D. | | | | | | | |
| 29c. License number D26265 | | | | | | | |
| 29d. Date signed (Month, Day, Year) 7/26/97 | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Jaime F. Marquez, M.D. 7610 Carroll Ave # 350 Takoma Park MD 20912 | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 28 1997 | | | | | | | |
| 32. Registrar's Signature Lisa Davidson-Randall | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25340

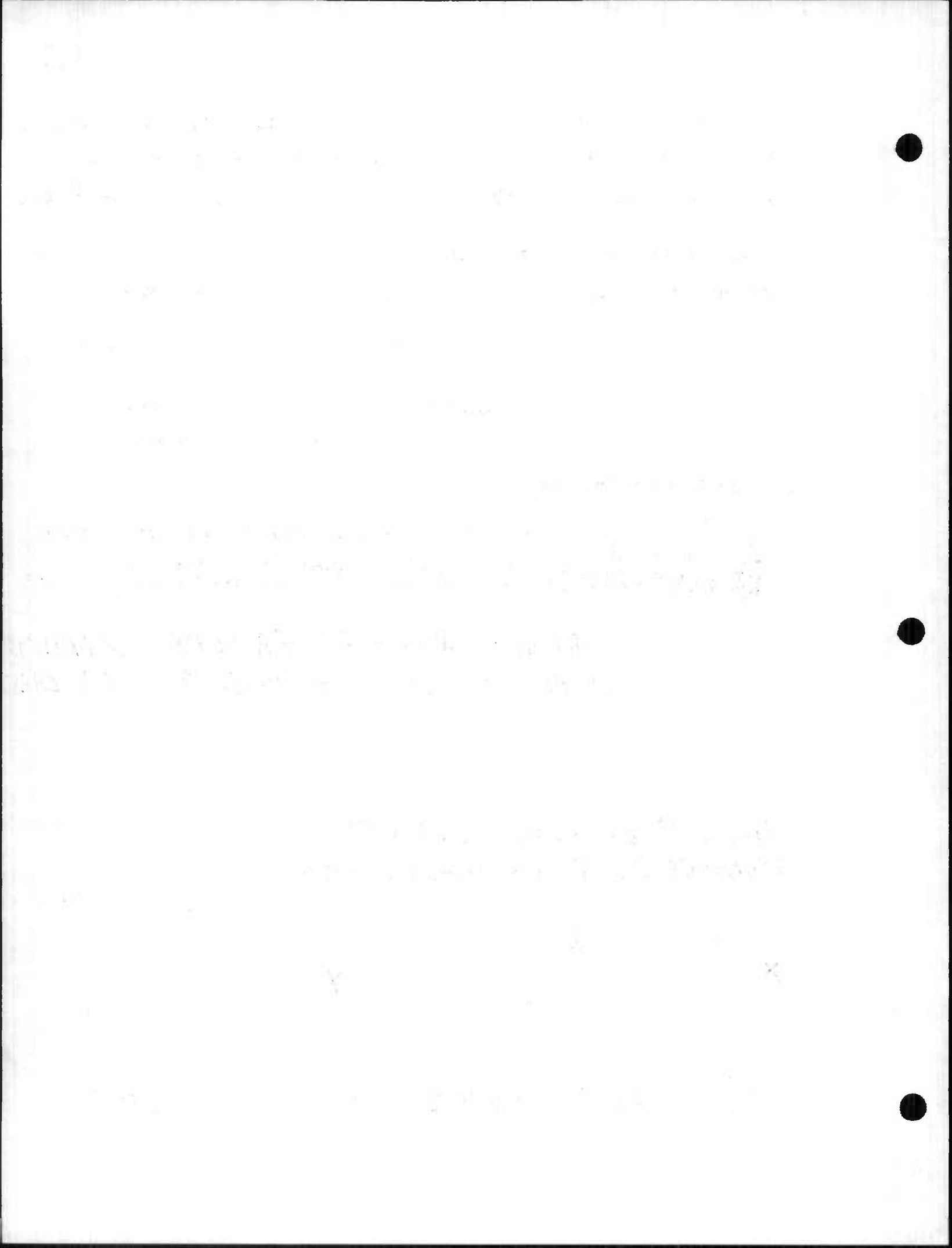
Certificate of Death

Reg. No.

| | | | | | |
|---|---|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Robert H. King, Sr. | | 2. Date of Death Month July Day 23 Year 1997 | | 3. Time of Death 10:00P. |
| | 4a. Facility Name (If not institution, give street and number) Holy Cross Hospital | | 4b. City, Town, or Location of Death Silver Spring | | 4c. County of Death Montgomery |
| Funeral Director | 5. Social Security Number 577-38-9627 | 6. Sex XX M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 68 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) Jan. 28, 1929 | | 9. Birthplace (State or Foreign Country) Washington, D.C. | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10a. State Maryland | | 10b. County Montgomery |
| | 10c. City, Town or Location Silver Spring | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number 13708 Modrad Way, #21 | | 10f. Zip Code 20904 | | 10g. Citizen of What Country? United States |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 Collage (1-4or 5+) Truck Driver | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver |
| | 17. Father's Name (First, Middle, Last) Howard B. King | | 18. Mother's Name (First, Middle, Maiden Surname) Bessie Follin | | 19. Informant's Name/Relationship (Type, Print) Michelle T. Magoon (daughter) |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory | | Date 7/25/1997 |
| | 20c. Location - City or Town, State Alexandria, Virginia | | 21. Signature of Funeral Service Licenses Donald V. Borgwardt | | 22. Name and Address of Facility Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immadiata Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. CARDIO RESPIRATORY FAILURE Due to (or as a consequence of): b. ADVANCED COPD + EMPHYSEMA Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | Approximate Interval Between Onset and Death SEV. MONTHS 2-3 YEARS | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CARCINOMA OF LUNGS (BILAT) SPONTANEOUS (R) PNEUMOTHORAX | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Michael G. Seremetis | |
| 29c. License number D03776 | | 29d. Date signed (Month, Day, Year) 7.24.97 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael G. Seremetis 3921 Fernara Dr Silver Spring MD | |
| 31. Date filed (Month, Day, Year) JUL 31 1997 | | 32. Registrar's Signature Julia Davidson-Rendell | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25341

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EMMA

KIRKLAND

2. Date of Death

Month

Day

Year

08 - 03 - 97

3. Time of Death

5:15 PM

4a. Facility Name (If not institution, give street and number)

Laurel Regional Hospital

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George's

5. Social Security Number

254-88-2297

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

70

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

August 24, 1926

9. Birthplace (State or Foreign Country)

Bamberg, South Carolina

Usual Residence of Decedent

10a. State
South
Carolina

10b. County

Bamberg County

10c. City, Town or Location

Denmark

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1352 South Palmetto Avenue

10f. Zip Code

29042

10g. Citizen of What Country?

United States
of America

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Charlie Moyer

18. Mother's Name (First, Middle, Maiden Surname)

Ollie Mae Rivers

19a. Informant's Name/Relationship (Type, Print)

Evelyn Hatcher/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3110 River Bend Court, Laurel, Maryland 20721

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Saint Phillips Church Cem

Date

8/10

20c. Location - City or Town, State

Govan,
South Carolina

21. Signature of Funeral Service Licensee

#M00690

22. Name and Address of Facility

Carroll Mortuary

416 Rail Road, Bamberg, South Carolina, 29003

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sepsis

Due to (or as a consequence of):

Hypercalcemia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Few Days

10-15 Days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Carcinoma Prostate

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

P. S. Autla MD

29c. License number

D42580

29d. Date signed (Month, Day, Year)

08/14/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P.S. Autla. 5632 Annapolis Rd. #13. BLADENSBURG MD 20710.

State
Registrar

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

Julia Davidson-Pondell

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25342

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|--|---|--|---|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) DAVID BEGGS KLINGER | | | | 2. Date of Death Month AUGUST Day 6 Year 1997 | | 3. Time of Death 5:01 PM | | |
| | 4a. Facility Name (If not institution, give street and number) NORTH ARUNDEL HOSPITAL ASSN | | | | 4b. City, Town, or Location of Death GLEN BURNIE | | 4c. County of Death ANNE ARUNDEL | | |
| Funeral Director | 5. Social Security Number 174-28-7973 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 60 Yrs. | | 8. Date of Birth (Month, Day, Year) DEC. 1, 1936 | | |
| | 9. Birthplace (State or Foreign Country) PENNSYLVANIA | | 10a. State MARYLAND | | 10b. County ANNE ARUNDEL | | 10c. City, Town or Location MILLERSVILLE | | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 8249 AHEARN ROAD | | 10f. Zip Code 21108 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 1959- If Yes, Give Year or Dates: 1963 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) N/A | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CARPENTER | | 16b. Kind of Business/Industry CONSTRUCTION | | 17. Father's Name (First, Middle, Last) EARL KLINGER | | 18. Mother's Name (First, Middle, Maiden Surname) MARY BEGGS | | 19. Informant's Name/Relationship (Type, Print) DONNA B. KLINGER (WIFE) | |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8249 AHEARN ROAD, MILLERSVILLE, MARYLAND 21108 | | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) CHESAPEAKE CREMATORY, INC. | | 20c. Location - City or Town, State BELTSVILLE, MD. | | 21. Signature of Funeral Service Licensee <i>Michael C. Zaffian</i> | |
| 22. Name and Address of Facility SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of death. Acute Myocardial Infarction | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| 28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| 29b. Signature and title of certifier <i>Hilary O'Herlihy MD</i> | | 29c. License number D15860 | | 29d. Date signed (Month, Day, Year) August 7, 1997 | | 30. Name and address of person who completed cause of death (Item 28a) (Type, Print) HILARY O'HERLIHY MD, 325 Hospital Dr #208, Glen Burnie MD 21061 | | 31. Date filed (Month, Day, Year) AUG 08 1997 | |
| 32. Registrar's Signature <i>John Davidson-Randall</i> | | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State
Registrar

SECRET - EX - DIVISION

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 25343**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CELESTINE E. KINS

2. Date of Death

Month 08 Day 01 Year 97

3. Time of Death

8:30 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

MARINER Health of Southern Maryland Clinton

4b. City, Town, or Location of Death

4c. County of Death

PRINCE GEORGES

5. Social Security Number

577-84-8494

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

30 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

NOV. 24, 1966

9. Birthplace (State or Foreign Country)

WASHINGTON, DC

Usual Residence of Decedent

10a. State

N/A

10b. County

N/A

10c. City, Town or Location

WASHINGTON, D.C.

10d. Inside City Limits

XX Yes 2 ☐ No

10e. Street and Number

1121 K ST. N.E.

10f. Zip Code

20002

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12TH

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SECRETARY

16b. Kind of Business/Industry

PRIVATE

17. Father's Name (First, Middle, Last)

NORMAN KING

18. Mother's Name (First, Middle, Maiden Surname)

ROSEANNA STONEY

19a. Informant's Name/Relationship (Type, Print)

RUBY WILLS/ AUNT

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1121 K STREET N.E., WASHINGTON, D.C. 20002

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GLENWOOD CEMETERY

Date

AUG. 06, 1997 WASHINGTON, D.C.

20c. Location - City or Town, State

21. Signature of Funeral Service Director

EDWARD M. DUDLEY

22. Name and Address of Facility

DUDLEY FUNERAL HOME
3200 RHODE ISLAND AVE., MT. RAINIER, MD 20712

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Human immune deficiency virus

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Many years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Asphyxiated candidiasis

Due to (or as a consequence of):

Months

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D25640

29d. Date signed (Month, Day, Year)

08-04-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KHOSROW DAVACHI, M.D. 1328 Southern Ave. S.E. Wash., D.C.

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

John A. ...

State
Registrar

Baltimore, Maryland 21215-0020

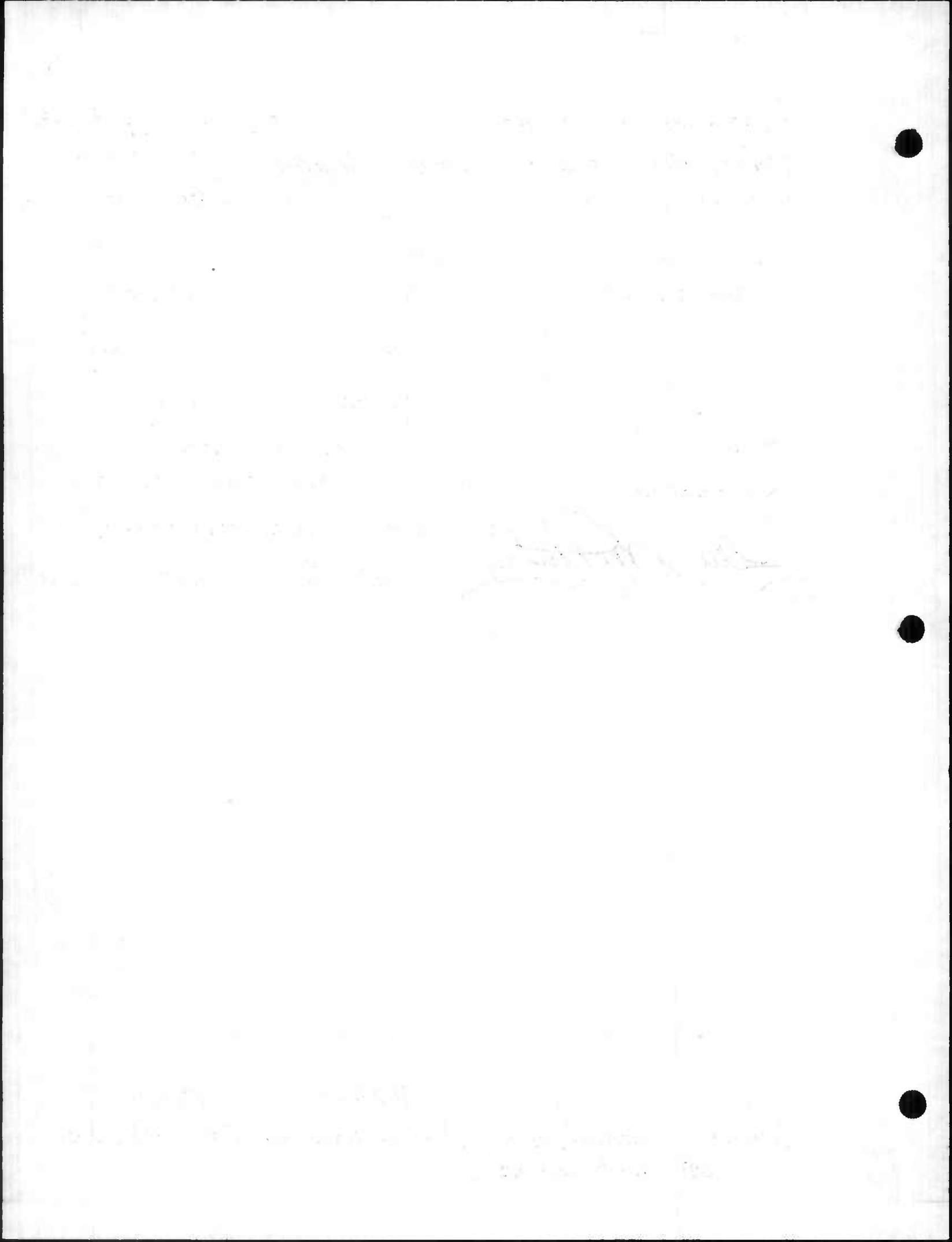
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25344

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | | | | |
|---|--|---|---|--------------------------------------|--|--|---|---|---|--------------------------|----------------------------------|--|---------------------------------------|----------------------------------|-----------------|------------------------|----------------------------------|----------------|-----------------------------------|----------------------------------|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Richard George Knapp | | | | 2. Date of Death Month Day Year August 6 1997 | | 3. Time of Death 11:15AM | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center | | | | 4b. City, Town, or Location of Death Annapolis | | 4c. County of Death Anne Arundel | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 102-18-3641 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 73 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) May 7 1924 | | 9. Birthplace (State or Foreign Country) New York | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | 10b. County Anne Arundel | 10c. City, Town or Location Annapolis | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | |
| | 10e. Street and Number 2609 Compass Drive | | | 10f. Zip Code 21401 | | 10g. Citizen of What Country? United States | | | | | | | | | | | | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Survey Statistition | | | 16b. Kind of Business/Industry Federal Government | | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last) William Thomas Knapp | | | | 18. Mother's Name (First, Middle, Maiden Surname) Beatrice Hayes | | | | | | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Ann K. Knapp (Wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2609 Compass Drive Annapolis, Maryland 21401 | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cemetery 8/8/97 Crownsville, Maryland | | Date | | 20c. Location - City or Town, State | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee <i>Donald S. Taylor</i> | | | | 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 | | | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | |
| | <table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Cardiac arrest</td> <td>Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death 0</td> </tr> <tr> <td>b. acute myocardial infarction</td> <td>Due to (or as a consequence of):</td> <td>30 mins.</td> </tr> <tr> <td>c. Hypertension</td> <td>Due to (or as a consequence of):</td> <td>5 years</td> </tr> <tr> <td>d. Coronary artery disease</td> <td>Due to (or as a consequence of):</td> <td>unknown</td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. Cardiac arrest | Due to (or as a consequence of): | Approximate Interval Between Onset and Death 0 | b. acute myocardial infarction | Due to (or as a consequence of): | 30 mins. | c. Hypertension | Due to (or as a consequence of): | 5 years | d. Coronary artery disease | Due to (or as a consequence of): |
| Immediate Cause (Final disease or condition resulting in death) | a. Cardiac arrest | Due to (or as a consequence of): | Approximate Interval Between Onset and Death 0 | | | | | | | | | | | | | | | | | |
| | b. acute myocardial infarction | Due to (or as a consequence of): | 30 mins. | | | | | | | | | | | | | | | | | |
| | c. Hypertension | Due to (or as a consequence of): | 5 years | | | | | | | | | | | | | | | | | |
| | d. Coronary artery disease | Due to (or as a consequence of): | unknown | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | | | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how Injury occurred | | | | | | | | | | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier <i>Barbara L. Bean MD</i> | | | | 29c. License number D39497 | | 29d. Date signed (Month, Day, Year) August 6th 1997 | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barbara L. Bean, M.D. 900 Bestgate Road Annapolis, Maryland 21401 | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 08 1997 | | 32. Registrar's Signature <i>Kelia Davidson-Randall</i> | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

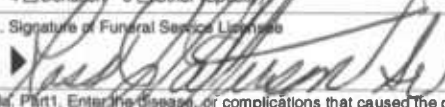
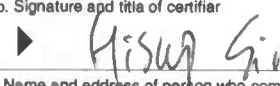
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25345

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|--|---|--|--|--|--|---|-----------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Mary Jane Loveless | | | | 2. Date of Death Month 08 Day 09 Year 97 | | 3. Time of Death 1300 | | | |
| | 4a. Facility Name (If not institution, give street and number) Medpointe 1 Price Drive | | | | 4b. City, Town, or Location of Death Elkton Md | | 4c. County of Death Cecil | | | |
| Funeral Director | 5. Social Security Number 217 - 58 - 8179 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 94 yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) March 20, 1903 | 9. Birthplace (State or Foreign Country) Maryland | | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MARYLAND | | 10b. County CECIL | | 10c. City, Town or Location PERRYVILLE | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 10e. Street and Number 1620 INGLESIDE AVE. | | | | 10f. Zip Code 21903 | | 10g. Citizen of What Country? U. S. A. | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSE WIFE | | | | 16b. Kind of Business/Industry ----- | | | |
| | 17. Father's Name (First, Middle, Last) JOHN SHELTON | | | | 18. Mother's Name (First, Middle, Maiden Surname) ELIZABETH PURNER | | | | | |
| Physician /Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) FRED B. LOVELESS, Jr. | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21903 1620 INGLESIDE AVE., PERRYVILLE, MARYLAND | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) BETHEL CEMETERY | | Date | | 20c. Location - City or Town, State CHESAPEAKE CITY, MD. | | | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility LEE A. PATTERSON & SON FUNERAL HOME PERRYVILLE, MARYLAND. 21903-0188 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ARDS Due to (or as a consequence of): b. ASWD (ARDS) secondary to VASULIN DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hypertension Arteriosclerosis HT of Myocardium | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Arteriosclerosis HT of Myocardium | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| | 29b. Signature and title of certifier  | | | | 29c. License number 046412 | | 29d. Date signed (Month, Day, Year) 8/9/97 | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hi Sup Sim, M. D., 319 S. UNION AVE., HAVRE DE GRACE, MARYLAND | | | | | | | | | |
| | 31. Date filed (Month, Day, Year) AUG 12 1997 | | | | 32. Registrar's Signature  | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25346

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Tho Huu Ly

2. Date of Death

Month

Day

Year

July

26, 1997

3. Time of Death

1445

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

586-16-8498

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

57 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Aug. 23, 1939

9. Birthplace (State or Foreign Country)

Vietnam

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7715 Ivy Oak Drive

10f. Zip Code

20877

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Navar Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
Asian15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

18a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Engineer

16b. Kind of Business/Industry

Telecommunications

17. Father's Name (First, Middle, Last)

Dang Van Ly

18. Mother's Name (First, Middle, Maiden Surname)

Rot Thi Le

19a. Informant's Name/Relationship (Type, Print)

Chi Mai Pham (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7715 Ivy Oak Drive, Gaithersburg, MD 20877

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

7/29/97

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

Michael D. Culibay

22. Name and Address of Facility

DeVol Funeral Home
10 East Deer Park Drive
Gaithersburg, MD 2087723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Gastric Cancer

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

One Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael D. Culibay

29c. License number

033686

29d. Date signed (Month, Day, Year)

July 27, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kath Miller 1811 Park Philip Dr. Olney, MD 20852

31. Date filed (Month, Day, Year)

JUL 30 1997

32. Registrar's Signature

John Anderson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25347

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedant's Name (First, Middle, Last)

Joseph

Levengard

2. Date of Death

July 26, 1997

3. Time of Death

11:15PM

4a. Facility Name (If not institution, give street and number)

Hebrew Home of Greater Washington

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

577-16-4108

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

March 20, 1908

9. Birthplace (State or Foreign

Country)

Poland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5508 AMESFIELD COURT

10f. Zip Code

20853

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

unknown

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Electrician

16b. Kind of Business/Industry

Self

17. Father's Name (First, Middle, Last)

LOUIS J. LEVENGARD

18. Mother's Name (First, Middle, Maiden Surname)

MINDEL STAVSKY

19a. Informant's Name/Relationship (Type, Print)

HERBERT LEVENGARD/BROTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5508 AMESFIELD CT., ROCKVILLE, MARYLAND 20853

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

KING DAVID MEMORIAL GDNS. 7/28/97

Date

20c. Location - City or Town, State

FALLS CHURCH, VA.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.

1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. ASPIRATION PNEUMONIA

Due to (or as a consequence of):

b. DEMENTIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ISCHEMIC CARDIOMYOPATHY

RENAL INSUFFICIENCY

CHRONIC ANEMIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D20367

29d. Date signed (Month, Day, Year)

JULY 28, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. JOEL P. KALMAN, 6111 EXECUTIVE BLVD, ROCKVILLE, MARYLAND 20852-3976

31. Date filed (Month, Day, Year)

JUL 29 1997

32. Registrar's Signature

Julia Davidson-Rendell

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-638-0000.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25348

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Kum Soon Lee

2. Date of Death

July 22 1997

3. Time of Death

9:35 PM

4a. Facility Name (If not institution, give street and number)

20437 Sunbright Lane

4b. City, Town, or Location of Death

Germantown

4c. County of Death

Montgomery

5. Social Security Number

217-72-2295

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 20 1928

9. Birthplace (State or Foreign Country)

Korea

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Germantown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

20437 Sunbright Lane

10f. Zip Code

20874

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Asian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Jae Kyung Kim

18. Mother's Name (First, Middle, Maiden Surname)

Sook Hwan Oh

19a. Informant's Name/Relationship (Type, Print)

Yung Jae Lee

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20437 Sunbright Lane Germantown, Md. 20874

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Norbeck Memorial Park

Date

07/25/97

20c. Location - City or Town, State

Olney, Maryland

21. Signature of Funeral Service Licensee

Thomas J. Gregor

22. Name and Address of Facility

Hines/Rinaldi Funeral Home Inc.
11800 New Hampshire Ave. Silver Spring, MD. 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. HEPATOCELLULAR CARCINOMA
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Two months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. HEPATITIS B
Due to (or as a consequence of):

30 y

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Isabella Martire

29c. License number

D45014

29d. Date signed (Month, Day, Year)

July 23 - 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ISABELLA MARTIRE; 8379 CHERRY LANE, LAUREL, Md. 20707

31. Date filed (Month, Day, Year)

JUL 29 1997

32. Registrar's Signature

Isabella Martire

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25349

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MILTON

EARL

LYNCH

2. Date of Death

JULY

29

3. Time of Death
12-15 A.M.Funeral
Director

4a. Facility Name (If not Institution, give street and number)

HOSPITAL

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

215-12-3209

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76

8. Date of Birth (Month, Day, Year)

SEPT. 10, 1920

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10e. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

GLEN BURNIE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1702 SAUNDERS WAY

10f. Zip Code

21061

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No WW II
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MAIL CARRIER

16b. Kind of Business/Industry

U. S. POSTAL SERVICE

17. Father's Name (First, Middle, Last)

JOHN

WALLACE

WADE

LYNCH

18. Mother's Name (First, Middle, Maiden Surname)

OLGA

GERTRUDE

SCARVORUGH

19a. Informant's Name/Relationship (Type, Print)

ELEANOR L. LYNCH

(WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1702 SAUNDERS WAY, GLEN BURNIE, MD. 21061

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHESAPEAKE CREMATORY, INC. 7/29/97 BELTSVILLE, MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SINGLETON FUNERAL HOME,

1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. EXACERBATION OF CHRONIC
OBSTRUCTIVE AIRWAYS DISEASE

Approximate Interval Between Onset and Death

SIXTEEN DAYS

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

MULTIFOCAL ATRIAL TACHYCARDIA

CORONARY ARTERY DISEASE, DIABETES
MELLITUS, HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D51664

29d. Date signed (Month, Day, Year)

JULY 29 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

SUDHIR KUMAR AGGARWAL,
NORTH ARUNDEL HOSPITAL, 301 HOSPITAL DRIVE, GLEN BURNIE, MD 21061State
Registrar

31. Date filed (Month, Day, Year)

AUG 01 1997

32. Registrar's Signature

Julia Davidson-Randall

MILTON ELLIOTT LYNCH

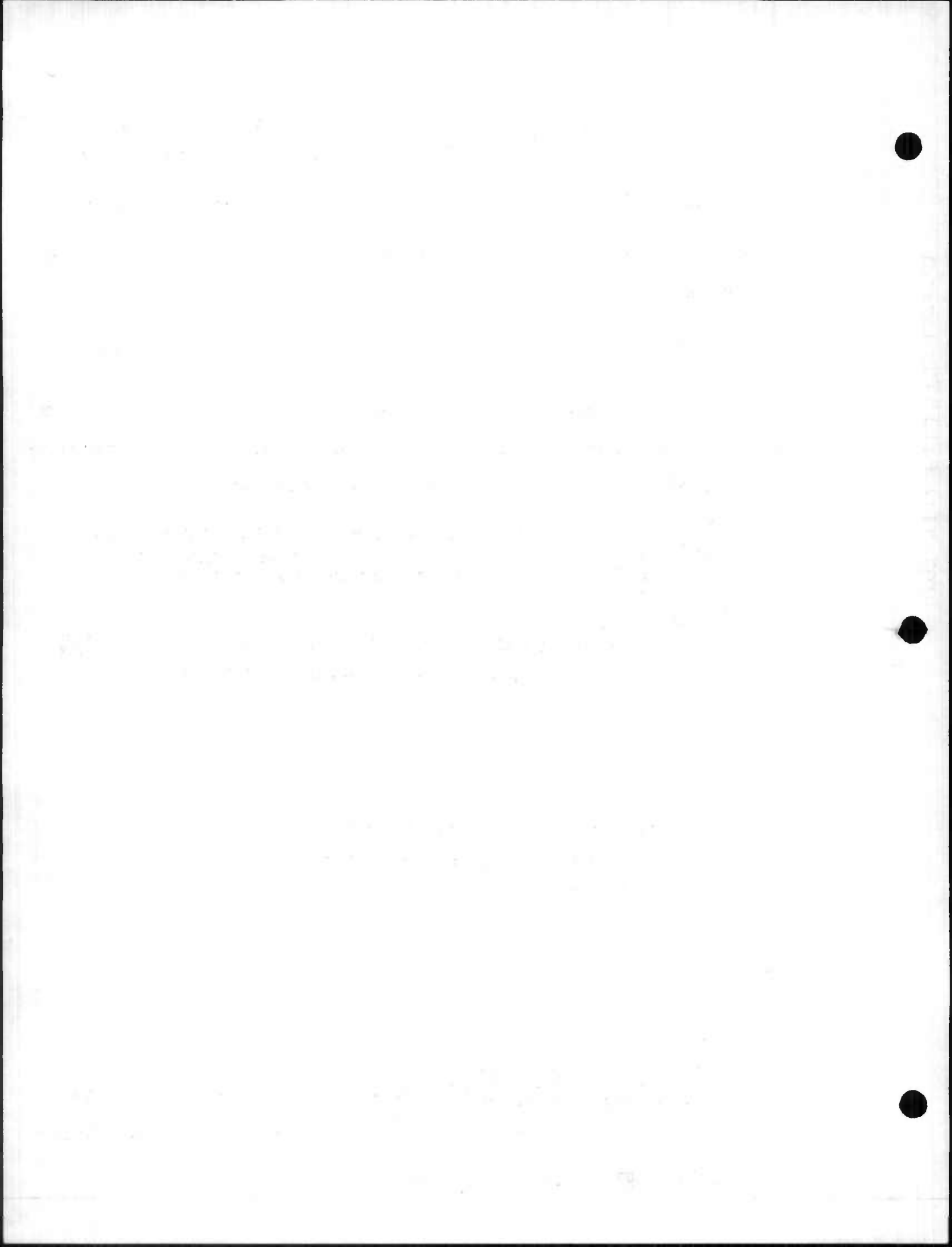
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25350

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | | | | | | | | | | | | | | | | | | | |
|--|----|---|---|---|--------------------------------|---|--|--|--|--|--|---|----|----------------------|---------|----|---------------------------|---------|----|--|--|----|--|--|
| 1. Decedent's Name (First, Middle, Last) LEVONIA FRANCIS LANHAM | | | | 2. Date of Death Month Day Year JULY 27, 1997 | | | | 3. Time of Death 2:45AM | | | | | | | | | | | | | | | | |
| 4a. Facility Name (If not institution, give street end number) MEDALANTIC NURSING HOME | | | | 4b. City, Town, or Location of Death SILVER SPRING | | | | 4c. County of Death MONTGOMERY | | | | | | | | | | | | | | | | |
| 5. Social Security Number 577-46-6336 | | 6. Sex 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 64 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) AUG. 02, 1932 | | 9. Birthplace (State or Foreign Country) SOUTH CAROLINA | | | | | | | | | | | | | | | | |
| Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | | | | | |
| 10a. State N/A | | 10b. County N/A | | 10c. City, Town or Location WASHINGTON, D.C. | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | |
| 10e. Street and Number 1441 CEDAR ST. S.E. #102 | | | | 10f. Zip Code 20020 | | | | 10g. Citizen of What Country? UNITED STATES | | | | | | | | | | | | | | | | |
| 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | | | | | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH College (1-4 or 5+) College (1-4 or 5+) | | | | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CASHIER | | | | 16b. Kind of Business/Industry PRIVATE | | | | | | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last) LAFAYETTE LANHAM | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) ELOISE BLAIR | | | | | | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) ARMENTA V. SHELTER/ DAUGHTER | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1602 RUSTON AVE., CAP. HGTS., MARYLAND 20743 | | | | | | | | | | | | | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) GLENWOOD CEMETERY | | Date AUG. 02, 1997 | | 20c. Location - City or Town, State WASHINGTON, D.C. | | | | | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee <i>Edward M. Dudley</i> EDWARD M. DUDLEY | | | | 22. Name and Address of Facility DUDLEY FUNERAL HOME 3200 RHODE ISLAND AVE., MT. RAINIER, MD 20712 | | | | | | | | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </td> <td>a.</td> <td>METASTATIC CARCINOMA</td> <td>2 MONTH</td> </tr> <tr> <td>b.</td> <td>URINARY BLADDER CARCINOMA</td> <td>6 MONTH</td> </tr> <tr> <td>c.</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table> | | | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. | METASTATIC CARCINOMA | 2 MONTH | b. | URINARY BLADDER CARCINOMA | 6 MONTH | c. | | | d. | | |
| Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. | METASTATIC CARCINOMA | 2 MONTH | | | | | | | | | | | | | | | | | | | | | |
| | b. | URINARY BLADDER CARCINOMA | 6 MONTH | | | | | | | | | | | | | | | | | | | | | |
| | c. | | | | | | | | | | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | | | | | | | | | | | | | | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier <i>Cezar A. Lopez MD</i> | | | | 29c. License number D15405 | | 29d. Date signed (Month, Day, Year) July 31, 1997 | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CEZAR A. LOPEZ, MD | | | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 31 1997 | | | | 32. Registrar's Signature <i>Johan Davidson-Randall</i> | | | | | | | | | | | | | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25351

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|---|---|--------------------------------|--|---|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Alice W. Lee | | | | 2. Date of Death Month: July Day: 30 Year: 1997 | | | | 3. Time of Death 9:00 PM | |
| | 4a. Facility Name (If not institution, give street and number) Wilson Health Care Facility | | | | 4b. City, Town, or Location of Death Gaithersburg | | | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 058-56-0088 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 84 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | |
| | 8. Date of Birth (Month, Day, Year) September 11, 1912 | | 9. Birthplace (State or Foreign Country) Pennsylvania | | Usual Residence of Decedent | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Gaithersburg | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 10e. Street and Number 301 Russell Avenue | | | | 10f. Zip Code 20877 | | 10g. Citizen of What Country? United States | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4 or 5+) 2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife | | 16b. Kind of Business/Industry Own Home | | | | | |
| | 17. Father's Name (First, Middle, Last) John Worsham | | | | 18. Mother's Name (First, Middle, Maiden Surname) Alice Edley | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Allyson Browne | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1287 North Van Dorn Street Alexandria, VA 22304 | | | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake crematory, Inc. | | Date 8/1/97 | | 20c. Location - City or Town, State Beltsville, Maryland | | | |
| | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Avenue, N.W. Washington, D.C. 20012 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Normal Pressure Hydrocephalus Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death Years | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Hypercholesterolemia | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Byrd D. Johnson M.D. | | 29c. License number D-19042 | | 29d. Date signed (Month, Day, Year) July 31, 1997 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Byrd D. Johnson M.D. 911 Russell Avenue Gaithersburg, Maryland 20879 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 01 1997 | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

10

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25352
Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|--|--|---|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) CLYDE WAYNE MORRIS | | | | 2. Date of Death Month Day Year AUG. 10 1997 | | 3. Time of Death 9:25 AM | |
| | 4a. Facility Name (if not institution, give street and number) SOUTHEASTERN AID. HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death CLINTON | | 4c. County of Death PRINCE GEORGE | |
| Funeral Director | 5. Social Security Number 308-40-7837 | | 8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (in yrs. last birthday) 57 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) JULY 30, 1940 | 9. Birthplace (State or Foreign Country) MARYLAND |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MARYLAND | | 10b. County CHARLES | | 10c. City, Town or Location WALDORF | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 6017 SIRENIA PLACE | | | | 10f. Zip Code 20603 | | 10g. Citizen of What Country? UNITED STATES | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BUILDING ENGINEER | | 16b. Kind of Business/Industry PRINCE GEORGE'S COUNTY GOVERNMENT | | |
| 17. Father's Name (First, Middle, Last) ALLEN THOMAS MORRIS | | | | | 18. Mother's Name (First, Middle, Maiden Surname) MILDRED WELCH | | | |
| 19a. Informant's Name/Relationship (Type, Print) REBECCA F. MORRIS - SPOUSE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6017 SIRENIA PLACE, WALDORF, MARYLAND 20603 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) TRINITY MEMORIAL GARDENS | | Data AUGUST 14, 1997 | | 20c. Location - City or Town, State WALDORF, MD | | |
| 21. Signature of Funeral Service Licensee MARK G. BROHAWN MO0053 | | | | 22. Name and Address of Facility THE HUNT FUNERAL HOME, INC. P.O. BOX 156, WALDORF, MARYLAND 20604 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. PNEUMONIA Due to (or as a consequence of): b. EMPHYSEMA Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death 1 WEEK YEARS |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. THROMBOCYTOPENIA | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier [Signature] | | 29c. License number D-18545 | | 29d. Date signed (Month, Day, Year) AUG. 10, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P. WISOTSKY MD 700 OLD LINE COURT WALDORF, MD 20603 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 12 1997 | | 32. Registrar's Signature [Signature] | | | | | | |

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25353

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|---|---|---|--|---|---|---|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JESSIE B. MARTIN | | | | 2. Date of Death Month 7 Day 27 Year 97 | | | | 3. Time of Death 4:45 PM | | |
| | 4a. Facility Name (If not Institution, give street and number) Chesapeake Health Care | | | | 4b. City, Town, or Location of Death Arnold | | | | 4c. County of Death Anne Arundel | | |
| Funeral Director | 5. Social Security Number 221-50-4165 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 91 Yrs. | | If Under 1 Year Months Days Hours Min. | | 8. Date of Birth (Month, Day, Year) 05-18-06 | | |
| | 10a. State Maryland | | 10b. County Anne Arundel | | 10c. City, Town or Location Arnold | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 10e. Street and Number 305 College Parkway | | 10f. Zip Code 21012 | | 10g. Citizen of What Country? U.S.A. | | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry At home | | 17. Father's Name (First, Middle, Last) James Brown | | 18. Mother's Name (First, Middle, Maiden Surname) Agnes Chapman | | | |
| 19e. Informant's Name/Relationship (Type, Print) June Garduno | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Holly 891 Harry Drive West, Annapolis, MD 21401 | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Gracelawn Mem. Park | | 20c. Location - City or Town, State 07-31-97 New Castle, DE | | | |
| 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility Beeson Memorial Services 2053 Pulaski Highway, Newark, DE 19702 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cerebrovascular accident | | Approximate Interval Between Onset and Death 7 yrs | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| Immediate Cause (Final disease or condition resulting in death) Dementia | | Due to (or as a consequence of): Deep Vein Thrombosis | | Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Deep Vein Thrombosis | | Due to (or as a consequence of): | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier  | |
| 29c. License number D40519 | | 29d. Date signed (Month, Day, Year) 7-27-97 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C. V. Cyriac, M.D., 8109 Ritchie Highway, Pasadena, MD 21122 | | 31. Date filed (Month, Day, Year) AUG 07 1997 | | 32. Registrar's Signature  | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25354

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|--|---|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Elwood F. Mathieson, Jr. | | | | 2. Date of Death Month July Day 26 Year 1997 | | 3. Time of Death 6:45P. | |
| | 4a. Facility Name (If not institution, give street and number) 9019 1st Street | | | | 4b. City, Town, or Location of Death Lanham | | 4c. County of Death Prince George's | |
| Funeral Director | 5. Social Security Number 579-52-2836 | | 6. Sex XX M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 55 Yrs. | | 8. Date of Birth (Month, Day, Year) 12-12-1941 | |
| | 9. Birthplace (State or Foreign Country) Washington, D.C. | | | | | | | |
| Usual Residence of Decedent | | | | | | | | |
| 10a. State Maryland | | 10b. County Prince George's | | 10c. City, Town or Location Lanham | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 9019 1st Street | | 10f. Zip Code 20706 | | 10g. Citizen of What Country? United States | | | | |
| 11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1960-1962 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Public Accountant | | | 16b. Kind of Business/Industry Self Employed | |
| 17. Father's Name (First, Middle, Last) Elwood F. Mathieson, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname) Bertha F. Lonas | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Linda M. Mathieson (wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as #10 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory | | Date 7/29/1997 | | 20c. Location - City or Town, State Alexandria, Virginia | | |
| 21. Signature of Funeral Service Licenses Donald V. Borgwardt | | | | 22. Name and Address of Facility Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Respiratory Failure Due to (or as a consequence of): b. Lung Cancer Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Asplenic Anemia Asplenic | | | | | | | | Approximate Interval Between Onset and Death minute 23 months |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Asplenic Anemia Asplenic | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Dr. [Signature] | | 29c. License number 044944 | | 29d. Date signed (Month, Day, Year) 7/28/97 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stanley Walker, M.D. 4110 Memorial Hospital Baltimore MD 21218 | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 31 1997 | | 32. Registrar's Signature J. Davidson-Randall | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25355

Amended #18, 7/28/97, JW, Montg. Cty.

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOSEPHINE M. MAYNARD

2. Date of Death

July 21 1997

3. Time of Death

5: P.M.

4a. Facility Name (If not institution, give street and number)

CARE MATRIX NURSING HOME

4b. City, Town, or Location of Death

SILVER SPRING,

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

577-18-0835

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 22, 1910

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Landover

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1603 Woodhill Court

10f. Zip Code

20785

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: African American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Daniel Johnson

18. Mother's Name (First, Middle, Maiden Surname)

Unavailable Clara Belle Smith

19a. Informant's Name/Relationship (Type, Print)

Norman K. Prince Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3714 Leeds Drive, Suitland, Maryland 20746

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lincoln Memorial

Date

7/29/97

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

Harry J. Robinson

22. Name and Address of Facility

McGuire Funeral Service, Inc.

7400 Georgia Ave. N.W., Washington, D.C. 20012

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute myelogenous leukemia/20q deletion about 1 year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

dementia

diabetes

severe anemia

depression

high blood pressure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Ruth Kevers Cohen M.D. D33159

29c. License number

29d. Date signed (Month, Day, Year)

July 22, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Ruth Kevers-Cohen M.D. 8700 Georgia Ave #400 Silver Spring MD 20910

31. Date filed (Month, Day, Year)

JUL 28 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25356

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JOHN DONALD MURPHY | | | | 2. Date of Death Month Day Year July 24, 1997 | | 3. Time of Death 4:15 pm | |
| | 4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital | | | | 4b. City, Town, or Location of Death Takoma Park | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 579-38-5551 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 75 Yrs. | | 8. Date of Birth (Month, Day, Year) Oct. 19, 1921 | |
| | 9. Birthplace (State or Foreign Country) New York | | 10a. State Maryland | | 10b. County Prince George's | | 10c. City, Town or Location Hyattsville | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 2600 Queens Chapel Road #110 | | 10f. Zip Code 20782 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Linguist | | 16b. Kind of Business/Industry Publishing | | | |
| | 17. Father's Name (First, Middle, Last) James Murphy | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Blanke | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Patrick A. O'Sullivan | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 417 Waterford Road Silver Spring, Maryland 20901 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Olivet Cemetery | | 20c. Location - City or Town, State Washington, D.C. | | 20d. Date 7/30/97 | |
| | 21. Signature of Funeral Service Licensee William L. Byrd | | | | 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hypoxia Due to (or as a consequence of): b. Respiratory Failure Due to (or as a consequence of): c. Chronic obstructive lung disease Due to (or as a consequence of): d. | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| Physician /Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive Heart Failure cardiac arrhythmia | | | | | | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 28g. Date signed (Month, Day, Year) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier Rashid y. n | | | | 29c. License number 039372 | | 29d. Date signed (Month, Day, Year) July 24 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 344 University Blvd west Silver Spring MD 20901 | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 30 1997 | | | | 32. Registrar's Signature John Davidson-Randell | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1. The first part of the paper is devoted to a general discussion of the problem. It is shown that the problem is well-posed and that the solution exists and is unique.

2. In the second part, the problem is reduced to a system of ordinary differential equations. This is done by using the method of characteristics.

3. The third part of the paper is devoted to the numerical solution of the problem. It is shown that the numerical solution is stable and convergent.

4. In the fourth part, the results of the numerical solution are compared with the analytical solution. It is shown that the numerical solution is in good agreement with the analytical solution.

5. The fifth part of the paper is devoted to the conclusion. It is shown that the problem is well-posed and that the solution exists and is unique.

6. In the sixth part, the problem is reduced to a system of ordinary differential equations. This is done by using the method of characteristics.

7. The seventh part of the paper is devoted to the numerical solution of the problem. It is shown that the numerical solution is stable and convergent.

8. In the eighth part, the results of the numerical solution are compared with the analytical solution. It is shown that the numerical solution is in good agreement with the analytical solution.

9. The ninth part of the paper is devoted to the conclusion. It is shown that the problem is well-posed and that the solution exists and is unique.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25357

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|--|---|--|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Maxine C. Montgomery | | | | 2. Date of Death Month Day Year July 29, 1997 | | 3. Time of Death 10:15 AM | | | |
| | 4a. Facility Name (If not institution, give street and number) 3501 Twin Branches Court | | | | 4b. City, Town, or Location of Death Silver Spring | | 4c. County of Death Montgomery | | | |
| Funeral Director | 5. Social Security Number 134-36-2508 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 87 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) February 26, 1910 | | 9. Birthplace (State or Foreign Country) Colorado | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Silver Spring | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number 3501 Twin Branches Court | | | | 10f. Zip Code 20906 | | 10g. Citizen of What Country? United States | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+ | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | 16b. Kind of Business/Industry Own Home | | | |
| | 17. Father's Name (First, Middle, Last) Earl Cooley | | | | 18. Mother's Name (First, Middle, Maiden Surname) Helen May West | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Royal M. Montgomery husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3501 Twin Branches Court, Silver Spring, MD 20906 | | | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory | | Data 7-30-97 | | 20c. Location - City or Town, State Beltsville, Maryland | | | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, MD 20910 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ovarian Carcinoma Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | Approximate Interval Between Onset and Death 1 year |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number D 35635 | | 29d. Date signed (Month, Day, Year) July 29, 1997 | | | | |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) Joseph Kaplan, M. D., 18111 Prince Philip Drive, #327, Olney, MD 20832 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 30 1997 | | 32. Registrar's Signature  | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25358

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Helen Virginia Emerson Miller

2. Date of Death

Month Day Year
July 29, 1997

3. Time of Death

5:55 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

579-05-4978

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 5, 1908

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10020 Sinnott Drive

10f. Zip Code

20817

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
White15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Robert Bruce Emerson

18. Mother's Name (First, Middle, Maiden Surname)

Mae Koehler

19a. Informant's Name/Relationship (Type, Print)

Helen M. Thompson / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10022 Sinnott Drive, Bethesda, Maryland 20817

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)August 2, 1997
Gate of Heaven Cemetery

Date

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

Barbara J. McMullen-Laurence

MO0831

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc.
7557 Wisconsin Avenue, Bethesda, Maryland 20814-350123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)a. *Respiratory Failure*
Due to (or as a consequence of):

24 hr

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Lastb. *Aspiration pneumonia*
Due to (or as a consequence of):

72 hr

c. *Buccal Obstruction*
Due to (or as a consequence of):

72 hrs

d. *Fecal impaction*
Due to (or as a consequence of):

72 hrs +

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*MULTIPLE vertebral body compression Fractures**OSTEOPOROSIS*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural
2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide5 ☐ Pending
Investigation
6 ☐ Could not be
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician2 ☐ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

T. J. McNamara, MD

29c. License number

D 32610

29d. Date signed (Month, Day, Year)

7-29-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

T. J. McNAMARA, MD 5602 Shields Dr. Bethesda, Maryland 20817

31. Date filed (Month, Day, Year)

AUG 01 1997

32. Registrar's Signature

*John Davidson-Randall*State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25359

Amend # 1 8/6/97 cms AA. Co Health Certificate of Death

Reg. No.

| | | | | | | |
|--|---|--|---|--------------------------------|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) James W McCready, Sr. | | 2. Date of Death Month Day Year August 4 1997 | | 3. Time of Death 8:35 PM | |
| | 4a. Facility Name (If not institution, give street and number) 100 Silopanna Road | | 4b. City, Town, or Location of Death Annapolis | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 214-30-3234 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 86 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Sept 24 1910 |
| | 9. Birthplace (State or Foreign Country) Maryland | | | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10a. State MD | | 10b. County Anne Arundel | |
| | 10c. City, Town or Location Annapolis | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 10e. Street and Number 100 Silopanna Road | | 10f. Zip Code 21403 | | 10g. Citizen of What Country? United States | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Chauffer | | 16b. Kind of Business/Industry United States Naval Academy | |
| | 17. Father's Name (First, Middle, Last) John McCready | | 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Buckler | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Evelyn Bacon (Daughter) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1933 Fairfax Road Annapolis, Maryland 21401 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Mary's Cemetery Aug. 7, 1997 | | 20c. Location - City or Town, State Annapolis, Maryland | |
| | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Cardiopulmonary Arrest</u> Dua to (or as a consequence of): b. <u>CCA</u> Dua to (or as a consequence of): c. <u>HTN</u> Dua to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | Approximate Interval Between Onset and Death |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>D. M</u> <u>CHF</u> | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier | | 29c. License number D26373 | |
| State Registrar | 29d. Date signed (Month, Day, Year) August 5, 1997 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (410-224-2222) Robert M. Greenfield, M.D. 139 Old Solomons Island Rd. Annapolis, MD 21401 | | | |
| | 31. Date filed (Month, Day, Year) AUG 06 1997 | | 32. Registrar's Signature | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research.

2. The second part of the report is a detailed description of the methods used in the study. It includes a discussion of the experimental design, the data collection procedures, and the statistical analysis techniques.

3. The third part of the report is a presentation of the results of the study. It includes a discussion of the findings, a comparison of the results with previous research, and a conclusion about the significance of the study.

4. The fourth part of the report is a discussion of the implications of the study. It includes a discussion of the limitations of the study, the strengths of the findings, and the potential for future research.

5. The fifth part of the report is a summary of the study. It includes a brief overview of the main findings and a final conclusion about the significance of the study.

6. The sixth part of the report is a list of references. It includes a list of all the sources used in the study, including books, articles, and other documents.

7. The seventh part of the report is an appendix. It includes a list of all the data collected during the study, as well as any other information that may be useful for understanding the results of the study.

8. The eighth part of the report is a final conclusion. It includes a brief summary of the main findings and a final statement about the significance of the study.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25360

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Keith McBryde

2. Date of Death

Month Day Year
July 21, 1997

3. Time of Death

2:15 AM

4a. Facility Name (If not institution, give street and number)

Prince Georges Hospital

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince Georges

Funeral
Director

5. Social Security Number

215-86-7843

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

33 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

April 20, 1964 Washington, DC

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

MD

10b. County

PG

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

6500 Riggs Rd.

10f. Zip Code

20783

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married ☐ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

6th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Food Service

16b. Kind of Business/Industry

NIH

17. Father's Name (First, Middle, Last)

Johnny Daves

18. Mother's Name (First, Middle, Maiden Surname)

Mary Lee Butler

19a. Informant's Name/Relationship (Type, Print)

Mary McBryde - Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1524 F Street N.E. #110, Wash., DC 20002

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glenwood Cemetery

Date

8-13-97

20c. Location - City or Town, State

Washington, DC

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Marshall's Funeral Home, Inc.

4217 9th St. NW Washington, DC 20011

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

CARDIO RESPIRATORY FAILURE

Due to (or as a consequence of):

AIDS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

SEIZURE

Due to (or as a consequence of):

SEPSIS

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Medical Examiner1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MD

29c. License number

D42019

29d. Date signed (Month, Day, Year)

JULY 20 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LIRAN HOWDENRY

7350 VAN LAUREL

ROSEN RD MD 20707

31. Date filed (Month, Day, Year)

AUG 07 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25361

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ALBERT FRANK MODE

2. Date of Death

Month Day Year
AUGUST 2, 1997

3. Time of Death

8:15 P.M.

4a. Facility Name (If not institution, give street and number)

DULANEY TOWSON HEALTH CARE CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

5. Social Security Number

124-03-7053

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
MAR. 23, 1915

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

ANNAPOLIS

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

807 COXSWAIN WAY

10f. Zip Code

21401

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

DETECTIVE

16b. Kind of Business/Industry

CITY POLICE DEPARTMENT

17. Father's Name (First, Middle, Last)

JULIAN MODE

18. Mother's Name (First, Middle, Maiden Surname)

ELIZABETH (UNKNOWN)

19a. Informant's Name/Relationship (Type, Print)

FRANCES R. BELL, NIECE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7 PARLIAMENT COURT, BALTIMORE, MARYLAND 21212

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

FORT LINCOLN CEMETERY

Date

8/6/97

20c. Location - City or Town, State

BRENTWOOD, MARYLAND

21. Signature of Funeral Service Licensee

Lisa S. Johnson

22. Name and Address of Facility

FORT LINCOLN FUNERAL HOME
3401 BLADENSBURG RD., BRENTWOOD, MARYLAND 20722

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Encephalopathy*
Due to (or as a consequence of):

b. *Sepsis*
Due to (or as a consequence of):

c. *pneumonia*
Due to (or as a consequence of):

d. *Neutropenia*
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Bashar Karakash, M.D.

29c. License number

D47813

29d. Date signed (Month, Day, Year)

August 3 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3007 E. Northern Parkway Baltimore MD 21214 BASHAR KARAKASH

31. Date filed (Month, Day, Year)

AUG 04 1997

32. Registrar's Signature

John Anderson-Randall

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

1. The first part of the document is a letter from the President of the United States to the Congress, dated January 1, 1861. It is a very important document, as it is the first official communication of the new President to the new Congress. The letter is written in a very formal and dignified style, and it contains a great deal of information about the President's views on the issues of the day.

2. The second part of the document is a report from the Secretary of the Treasury, dated January 1, 1861. It is a very important document, as it contains a great deal of information about the financial state of the United States at the time. The report is written in a very formal and dignified style, and it contains a great deal of information about the Treasury's views on the issues of the day.

3. The third part of the document is a report from the Secretary of the Interior, dated January 1, 1861. It is a very important document, as it contains a great deal of information about the state of the interior of the United States at the time. The report is written in a very formal and dignified style, and it contains a great deal of information about the Secretary's views on the issues of the day.

4. The fourth part of the document is a report from the Secretary of the War, dated January 1, 1861. It is a very important document, as it contains a great deal of information about the state of the war at the time. The report is written in a very formal and dignified style, and it contains a great deal of information about the Secretary's views on the issues of the day.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 25362

Reg. No.

| | | | | | | | | | | | |
|--|--|--|---|---|--|--------------------------|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Florence Martin | | | | 2. Date of Death Month Day Year July 31, 1997 | | | | 3. Time of Death 9:35 am | | |
| | 4a. Facility Name (If not institution, give street and number) Collington Episcopal Life Care Community | | | | 4b. City, Town, or Location of Death Mitchellville | | | | 4c. County of Death Prince George's | | |
| Funeral Director | 5. Social Security Number 397-46-2787 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 91 Yrs. | | 8. Date of Birth (Month, Day, Year) May 1, 1906 | | 9. Birthplace (State or Foreign Country) Bloomington, WI | | |
| | Usual Residence of Decedent | | | | 10a. State Maryland | | | | 10b. County Prince George's | | 10c. City, Town or Location Mitchellville |
| To Be Completed by Funeral Director | 10a. State | | 10b. County | | 10c. City, Town or Location | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | 10e. Street and Number 10450 Lottsford Road | | | | 10f. Zip Code 20721 | | | | 10g. Citizen of What Country? U.S.A. | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 years | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | | 16b. Kind of Business/Industry Own home | | |
| | 17. Father's Name (First, Middle, Last) John Burdette Ludden | | | | 18. Mother's Name (First, Middle, Maiden Surname) Belva Gladys Stone | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Carolyn M. Miller - Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4122 Woodberry Street, Hyattsville, Maryland 20782 | | | | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory | | Date 8/01/97 | | 20c. Location - City or Town, State Alexandria, Virginia | | | | |
| | 21. Signature of Funeral Service Licensee H. Constance Gasch | | | | 22. Name and Address of Facility Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, Md. 20781 | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiopulmonary Arrest Due to (or as a consequence of): b. Cerebrovascular Accident Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death Months | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Myeloproliferative Disorder | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier Stacy Thomas | | | | 29c. License number D37934 | | 29d. Date signed (Month, Day, Year) 7/31/97 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephanie Trifoglio MD 7500 Greenway Center Dr Greenbelt MD 20770 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 04 1997 | | | | 32. Registrar's Signature John Andrew Randall | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25363

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|--|---|--|--|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Nguu Van Nguyen | | | | 2. Date of Death Month Day Year July 24, 1997 | | 3. Time of Death 9:00 PM | | |
| | 4e. Facility Name (If not institution, give street and number) 9858 Brookridge Court | | | | 4b. City, Town, or Location of Death Gaithersburg | | 4c. County of Death Montgomery | | |
| Funeral Director | 5. Social Security Number 214-33-1190 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 76 Yrs. | | 8. Date of Birth (Month, Day, Year) Dec. 20, 1920 | | |
| | 9. Birthplace (State or Foreign Country) Vietnam | | 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Gaithersburg | | |
| To Be Completed by Funeral Director | 10e. Street and Number 9858 Brookridge Court | | 10f. Zip Code 20879 | | 10g. Citizen of What Country? United States | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Asian | | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Senator | | 16b. Kind of Business/Industry Vietnam Government | | 17. Father's Name (First, Middle, Last) Thu Nguyen | | |
| | 18. Mother's Name (First, Middle, Maiden Surname) Nhe Tran | | 19e. Informant's Name/Relationship (Type, Print) Anh Hoang/Daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 676 College Parkway, Rockville, Maryland 20850 | | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | |
| Physician /Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory | | 20c. Date 7/27/97 | | 20d. Location - City or Town, State Alexandria, Virginia | | 21. Signature of Funeral Service Licensee Michael A. Calhoun | | |
| | 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877 | | 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Congestive cardiomyopathy Due to (or as a consequence of): b. Coronary artery disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | Approximate Interval Between Onset and Death 2 years 10 years | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| State Registrar | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | |
| | 29b. Signature and title of certifier Praveen K. Gupta, M.D. | | 29c. License number D37532 | | 29d. Date signed (Month, Day, Year) July 25, 1997 | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Praveen K. Gupta, M.D., 50 W. Edmonston Drive, Suite #202 Rockville, MD 20852 | | |
| 31. Date filed (Month, Day, Year) JUL 30 1997 | | 32. Registrar's Signature Julia Davidson-Randall | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25364

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|--|--|---|---|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Alice Delight Densmore North | | | | 2. Date of Death Month Day Year July 25, 1997 | | 3. Time of Death 2:10 A.M. | | |
| | 4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Health Center | | | | 4b. City, Town, or Location of Death Rockville | | 4c. County of Death Montgomery | | |
| Funeral Director | 5. Social Security Number 219-36-7670 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 92 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) August 19, 1904 | 9. Birthplace (State or Foreign Country) Vermont | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Takoma Park | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | 10e. Street and Number 312 Ethan Allen Ave. | | | | 10f. Zip Code 20912 | | 10g. Citizen of What Country? U.S.A. | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Registrar | | 16b. Kind of Business/Industry Montgomery County School | | | | |
| | 17. Father's Name (First, Middle, Last) Eugene E. Densmore | | | | 18. Mother's Name (First, Middle, Maiden Surname) Demis Mae Watson | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Gordon D. North/Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Marcia Ct. Rockville, MD 20851 | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Rock Creek Cemetery | | Date July 28, 1997 | | 20c. Location - City or Town, State Washington, DC | | |
| | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility Takoma Funeral Home, Inc. 254 Carroll St. NW Washington, DC 20012 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Congestive heart failure YRS Due to (or as a consequence of): Coronary artery disease YRS Due to (or as a consequence of): Hypertension YRS Due to (or as a consequence of): Cancer of the Breast YRS Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of Certifier <i>[Signature]</i> | | 29c. License number D35792 | | 29d. Date signed (Month, Day, Year) JULY 25, 1997 | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SWANSON RAO; 50 W. EDMONSTON DR, ROCKVILLE, MD-20852 | | | | | |
| 31. Date filed (Month, Day, Year) JUL 29 1997 | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 24a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25365

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|--|--|---|--|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Eva Ruth Nagelhout | | | | 2. Date of Death Month Day Year July 30 1997 | | 3. Time of Death 11:36pm | | |
| | 4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center | | | | 4b. City, Town, or Location of Death Annapolis | | 4c. County of Death Anne Arundel | | |
| Funeral Director | 5. Social Security Number 139-26-3369 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 88 Yrs. | | 8. Date of Birth (Month, Day, Year) Dec 18, 1908 | | |
| | 9. Birthplace (State or Foreign Country) New Jersey | | 10a. State MD | | 10b. County Anne Arundel | | 10c. City, Town or Location Severna Park | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 728 Ticonderoga Avenue | | 10f. Zip Code 21146 | | 10g. Citizen of What Country? USA | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cafeteria Worker | | 16b. Kind of Business/Industry New Jersey School System | | | | |
| | 17. Father's Name (First, Middle, Last) Ernest Spell | | | | 18. Mother's Name (First, Middle, Maiden Surname) Minnie Dunning | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Joan Dykstra/daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 728 Ticonderoga Ave., Severna Park, MD 21146 | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Valleau Cemetery | | Date Aug 2 1997 | | 20c. Location - City or Town, State Ridgewood, NJ | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ventricular Tachycardia Due to (or as a consequence of): b. Congestive Heart Failure Due to (or as a consequence of): c. Coronary Artery Disease Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 24 hr 12 hr YEARS | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| | 27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | 28d. Describe how Injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| State Registrar | 29a. Certifier (check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| | 29b. Signature and title of certifier | | 29c. License number 1350768424 | | 29d. Date signed (Month, Day, Year) 7/31/97 | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2003 Medical Parkway St 310 Annapolis MD | |
| | 31. Date filed (Month, Day, Year) AUG 05 1997 | | 32. Registrar's Signature | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25366

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Albert D. Nichols

2. Date of Death

Month Day Year
Aug. 2, 1997

3. Time of Death

11:00p.m.

4a. Facility Name (If not institution, give street and number)

2505 Afton Street

4b. City, Town, or Location of Death

Temple Hills

4c. County of Death

P.G.

Funeral
Director

5. Social Security Number

429 16 6156

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 1, 1921

9. Birthplace (State or Foreign Country)

Polaski Co., Ark

Usual Residence of Decedent

10a. State

Md.

10b. County

P.G.

10c. City, Town or Location

Temple Hills

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

2505 Afton Street

10f. Zip Code

20748

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married

☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates: 44 - 44

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11th grade

College (1-4 or 5+)

NONE

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

US GOVERNMENT EMPLOYEE

16b. Kind of Business/Industry

US GOVERNMENT

17. Father's Name (First, Middle, Last)

Jackson Nichols

18. Mother's Name (First, Middle, Maiden Surname)

Jessie Shaw

19a. Informant's Name/Relationship (Type, Print)

Frances E. Nichols

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Sames as; 10e,c,b,a,f.

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State

☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cheltenham Vet. Cem.

Date

8/6/97

20c. Location - City or Town, State

Cheltenham, Md.

21. Signature of Funeral Service Licensee

Juan Smith

22. Name and Address of Facility

John T. Rhines Company

3030 12th St., N.E. Wash., D.C. 20017

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Cerebral hemorrhage of prostate*
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was cause referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☐ Natural ☐ Pending investigation

☐ Accident ☐ Could not be determined

☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Gerald P. Batipps

29c. License number

10220

29d. Date signed (Month, Day, Year)

8/5/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GERALD P. BATIPPS, 1170 VARNUM ST NE, DC 20017

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

John Douglas Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25367

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Kiyone Okamoto

2. Date of Death

Month Day Year
July 24, 1997

3. Time of Death

1:25 PM

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

549-01-8442

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95 Yrs.

if Under 1 Year

Months Days

if Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 9, 1901

9. Birthplace (State or Foreign Country)

Japan

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Sandy Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

17340 Quaker Lane

10f. Zip Code

20860

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Japanese

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

(Unavailable) Umeki

18. Mother's Name (First, Middle, Maiden Surname)

Sue Higashiya

19a. Informant's Name/Relationship (Type, Print)

Toshiko Salzberg

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6342 31st Street, NW, Washington, DC 20015

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory

Date

7-28-97

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Ellen H. Rapp

22. Name and Address of Facility

Rapp Funeral Services, P. A.
933 Gist Avenue, Silver Spring, MD 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute myocardial infarction

Approximate Interval Between Onset and Death

2 HOURS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dennis M. Hannon

29c. License number

D23124

29d. Date signed (Month, Day, Year)

July 27, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DENNIS M. HANNON 346 OLANWOOD COURT, OLNEY MD 20832

31. Date filed (Month, Day, Year)

JUL 28 1997

32. Registrar's Signature

Lia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25368

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|---|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Peter D. Orahovats | | | | 2. Date of Death Month July Day 21 Year 1997 | | 3. Time of Death 06:59 p.m. | |
| | 4a. Facility Name (If not institution, give street and number) St. Mary's Hospital | | | | 4b. City, Town, or Location of Death Leonardtwn | | 4c. County of Death St. Mary's | |
| Funeral Director | 5. Social Security Number 141-26-2836 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 75 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) April 22, 1922 | 9. Birthplace (State or Foreign Country) Sofia, Bulgaria | |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | 10b. County St. Mary's | 10c. City, Town or Location Valley Lee | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number P.O. Box 169 | | | 10f. Zip Code 20692 | | 10g. Citizen of What Country? U.S.A. | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+) 5+ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Corporate Senior Executive | | | 16b. Kind of Business/Industry Pharmaceutical | | |
| | 17. Father's Name (First, Middle, Last) Dimitar Orahovats | | | | 18. Mother's Name (First, Middle, Maiden Surname) Theodora Sasselova | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Emanuela M. Orahovats Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2800 WI Ave. N.W., Apt. 803, Washington, DC 20007 | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Comfort Crematory | | 20c. Location - City or Town, State 7/28/97 Alexandria, Virginia | | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Joseph Gawler's Sons, Inc., 5130 WI Avenue, N.W. Washington, D.C. 20016 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Probable Myocardial Infarction sec. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | Approximate Interval Between Onset and Death |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how Injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and Title of certifier | | | | 29c. License number 14285 | | 29d. Date signed (Month, Day, Year) 7-22-97 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William D. Boyd, II M. D. 17 Jefferson Street Leonardtown, MD 20621 | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 29 1997 | | | | 32. Registrar's Signature | | | | |

State
Registrar

ORAHOVATS, PETER DIMITER

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

40

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25369

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Viola Sherwood O'Neill

2. Date of Death

Month Day Year
July 28, 1997

3. Time of Death

3:45AM

4a. Facility Name (If not institution, give street and number)

Fox Chase Rehabilitation & Nursing Center

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

578-20-5146

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

June 14, 1903

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7361 Heatherhill Court

10f. Zip Code

20817

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Corporate Office-
Real Estate Firm

17. Father's Name (First, Middle, Last)

William Sherwood

18. Mother's Name (First, Middle, Maiden Surname)

Mary Gartlin

19a. Informant's Name/Relationship (Type, Print)

Edward S. O'Neill / son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7361 Heatherhill Court, Bethesda, Maryland 20817

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Montgomery Crematorium, Inc.

Date

July 29, 1997

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

Barbara J. McMullen Lawrence M00831

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc.
7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

e. Stroke

Due to (or as a consequence of):

b. Arteriosclerotic Cerebrovascular Disease

Due to (or as a consequence of):

c. Senile Dementia

Due to (or as a consequence of):

d.

1 day

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Walter E. Goozh, M.D.

29c. License number

D01120

29d. Date signed (Month, Day, Year)

July 28, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Walter E. Goozh, M.D. 1299 Lambertson Drive, Silver Spring, Maryland 20902

31. Date filed (Month, Day, Year)

JUL 30 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25370

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Michael Enrico Oliveri

2. Date of Death

Month Day Year
July 29, 1997

3. Time of Death

9:42 AM

4a. Facility Name (If not institution, give street and number)

Bethesda Manor Care

4b. City, Town, or Location of Death

Chevy Chase

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

577-54-0020

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb. 29, 1912

9. Birthplace (State or Foreign Country)

Italy

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

Washington, DC

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

4745 Nebraska Avenue, NW

10f. Zip Code

20016

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☒ Yes ☐ No
If Yes, Give
Year or Dates: WW II13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12College (1-4 or 5+)
5+16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Dentist

16b. Kind of Business/Industry

Dentistry

17. Father's Name (First, Middle, Last)

Antonio Oliveri

18. Mother's Name (First, Middle, Maiden Surname)

Marietta Lamana

19a. Informant's Name/Relationship (Type, Print)

Michael A. Oliveri

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4512 MacArthur Blvd., NW, #3, Washington, DC 20007

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Chesapeake Crematory

Date

7-30-97

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensor

Eileen H. Rapp

22. Name and Address of Facility

Rapp Funeral Services, P. A.
933 Gist Avenue, Silver Spring, MD 2091023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Oral Cancer
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

months

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?
☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☒ Nursing Home☐ Residence ☐ Other (Specify)

27. Manner of Death

☐ Natural ☐ Pending
Investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?
☐ Yes ☒ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Lila T. McConnell, M.D.

29c. License number

D39452

29d. Date signed (Month, Day, Year)

July 29, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lila T. McConnell, M.D., #2 Wisconsin Circle, Chevy Chase, MD 20815

31. Date filed (Month, Day, Year)

JUL 30 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25371

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

VERONICA OWENS

2. Date of Death

Month Day Year
JULY 31, 1997

3. Time of Death

3:35 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

CITY

5. Social Security Number

215-11-0300

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

12

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

JULY 2 1985

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

ANNAPOLIS

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

608 FIRST STREET

10f. Zip Code

21403

10g. Citizen of What Country?

US

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6th

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

STUDENT

16b. Kind of Business/Industry

ANNAPOLIS MIDDLE SCHOOL

17. Father's Name (First, Middle, Last)

RONALD OWENS

18. Mother's Name (First, Middle, Maiden Surname)

E. VANESSA RANDALL

19a. Informant's Name/Relationship (Type, Print)

E. VANESSA RANDALL (MOTHER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

608 FIRST STREET ANNAPOLIS, MD. 21403

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ANNAPOLIS MEM. GARDENS

Date

8/6/97

20c. Location - City or Town, State

ANNAPOLIS, MD.

21. Signature of Funeral Service Licensee

Larry H. Reese

22. Name and Address of Facility

WM. REESE & SONS MORTUARY, P.A.
821 WEST ST. ANNAPOLIS, MD. 21401

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE PANCREATITIS

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 DAY

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RENAL FAILURE

METABOLIC ACIDOSIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Peter J. Mugayzel MD

29c. License number

D45651

29d. Date signed (Month, Day, Year)

JULY 31, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PETER J. MUGAYZEL, JR MD, THE JOHNS HOPKINS HOSPITAL, BALTIMORE MD

31. Date filed (Month, Day, Year)

AUG 05 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25372

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Maria Catalina Orellana

2. Date of Death

August 4, 1997

3. Time of Death

10:45 PM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

320-19-8546

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

45

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

8/22/52

9. Birthplace (State or Foreign Country)

El Salvador

Usual Residence of Decedent

10a. State

Md

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11530 Lockwood Drive

10f. Zip Code

20904

10g. Citizen of What Country?

El Salvador

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No
Specify: El Salvador

14. Race - American Indian, Black, White, etc.

Specify: Hispanic

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

Jose O Orellana

18. Mother's Name (First, Middle, Maiden Surname)

Maria J. Rodriguez

19a. Informant's Name/Relationship (Type, Print)

Alfredo Garcia (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11530 Lockwood Dr Silverspring Md 20904

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Natinoal

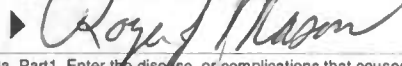
Date

8/9/97

20c. Location - City or Town, State

Laurel Md

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Sterling Funeral Service

1601 Kenilworth Ave NE Wash DC 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cirrhosis of Liver

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

few months

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypotension

Sepsis

Ascites

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

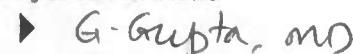
28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

M 46398

29d. Date signed (Month, Day, Year)

August 5, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

G. Gupta, MD, 121 Congressional Lane, # 409, Rockville, MD 20852

31. Date filed (Month, Day, Year)

AUG 07 1997

32. Registrar's Signature


State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

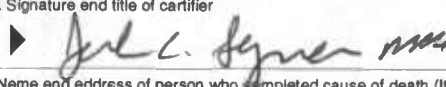
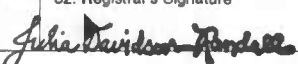
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25373

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | |
|--|---|---------------------------------|---|--------------------------------|---|---|---------------|---|-------------|---|---------------|----|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Jacob Paauwe Jr. | | 2. Date of Death Month July Day 30 Year 1997 | | 3. Time of Death 11:12 pm | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) The Kent and Queen Anne's Hospital, Inc. | | 4b. City, Town, or Location of Death Chestertown | | 4c. County of Death Kent | | | | | | | | |
| Funeral Director | 5. Social Security Number 192-34-0112 | 6. Sex 1 M 2 F | 7. Age (In yrs. last birthday) 84 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | | | | | | | | |
| | 8. Date of Birth (Month, Day, Year) April 3, 1913 | | 9. Birthplace (State or Foreign Country) Rotterdam The Netherlands | | | | | | | | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10a. State Maryland | | 10b. County Kent | | | | | | | | |
| | 10c. City, Town or Location Chestertown | | 10d. Inside City Limits 1 Yes 2 No | | | | | | | | | | |
| | 10e. Street and Number 326 Heron Point | | 10f. Zip Code 21620 | | 10g. Citizen of What Country? United States | | | | | | | | |
| | 11. Marital Status 3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: | | | | | | | | |
| | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4 or 5+) | | | | | | | | | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) High Pressure Engineer | | 16b. Kind of Business/Industry High Pressure Equipment Manufacturing | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last) Jacob Paauwe | | 18. Mother's Name (First, Middle, Maiden Surname) Jaapje Groenendyk | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Maryke Cottman Daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 207 Beverly Place, Wilmington, DE 19809 | | | | | | | | | | |
| | 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Gracelawn Memorial Park | | 20c. Location - City or Town, State 8/2/97 New Castle, DE | | | | | | | | |
| | 21. Signature of Funeral Service Licensee  MOOSIO | | 22. Name and Address of Facility Beeson Memorial Services 412 Philadelphia Pike, Wilmington, DE 19809 | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | |
| <table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>e. ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of):</td> <td>50 YRS</td> </tr> <tr> <td>b. PERIPHERAL VASCULAR DISEASE Due to (or as a consequence of):</td> <td>1 YR</td> </tr> <tr> <td>c. ISCHEMIC CANNULOPATHY Due to (or as a consequence of):</td> <td>10 YRS</td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> | | | | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | e. ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): | 50 YRS | b. PERIPHERAL VASCULAR DISEASE Due to (or as a consequence of): | 1 YR | c. ISCHEMIC CANNULOPATHY Due to (or as a consequence of): | 10 YRS | d. | |
| Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | e. ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): | 50 YRS | | | | | | | | | | | |
| | b. PERIPHERAL VASCULAR DISEASE Due to (or as a consequence of): | 1 YR | | | | | | | | | | | |
| | c. ISCHEMIC CANNULOPATHY Due to (or as a consequence of): | 10 YRS | | | | | | | | | | | |
| | d. | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown | | | | | | | | | | | | | |
| 24a. Was an autopsy performed? 1 Yes 2 No | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 Yes 2 No | | | | | | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 OOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | | | | | | | | | |
| 27. Manner of Death 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide | | | | | | | | | | | | | |
| 28a. Date of Injury (Month, Day, Year) | | | | | | | | | | | | | |
| 28b. Time of Injury M | | | | | | | | | | | | | |
| 28c. Injury at Work? 1 Yes 2 No | | | | | | | | | | | | | |
| 28d. Describe how Injury occurred | | | | | | | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | |
| 29b. Signature and title of certifier  | | | | | | | | | | | | | |
| 29c. License number 10-13824 | | | | | | | | | | | | | |
| 29d. Date signed (Month, Day, Year) 7-31-97 | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 06 1997 | | | | | | | | | | | | | |
| 32. Registrar's Signature  | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

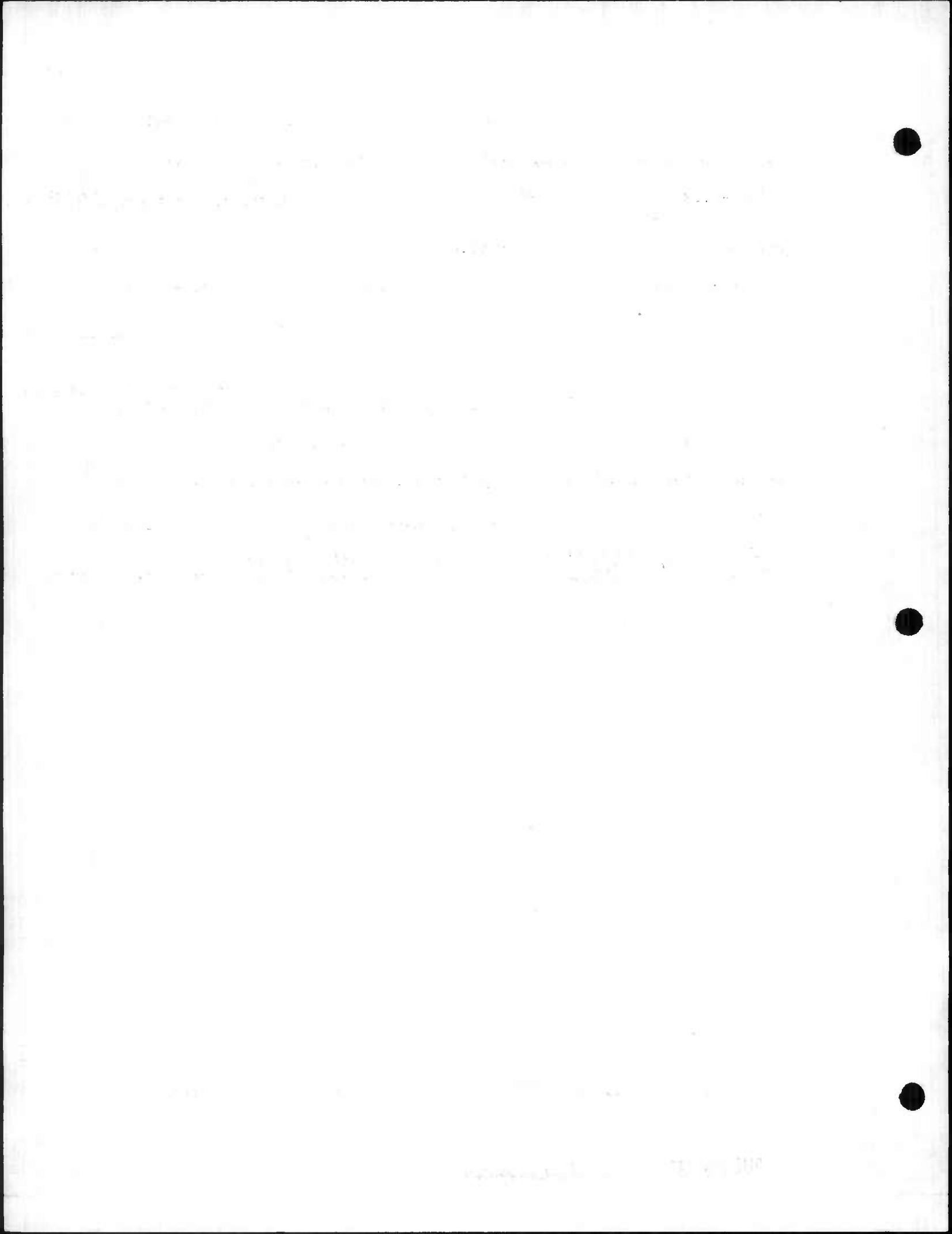
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25374

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WALTER F. POWELL

2. Date of Death

Month Day Year
July 23, 1997

3. Time of Death

5:00Pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Randolph Hills Nursing Center

4b. City, Town, or Location of Death

Wheaton

4c. County of Death

Montgomery

5. Social Security Number

218-16-0185

6. Sex

152 M 20 F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug 17, 1925

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md

10b. County

Montgomery

10c. City, Town or Location

Silver Spring,

10d. Inside City Limits

152 Yes 20 No

10e. Street and Number

1135 W. Univ Blvd,

10f. Zip Code

20902

10g. Citizen of What Country?

U.S.A.

11. Marital Status

10 Never Married 20 Married
30 Widowed 40 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

10 Yes 20 No
15 Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10 Yes 20 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6th Grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Hauling & Etc.

17. Father's Name (First, Middle, Last)

William Powell Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Bertha Dorsey

19a. Informant's Name/Relationship (Type, Print)

Bertha Stanton

(Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9487 Time Sweep Lane, Columbia, Md #21045

20a. Method of Disposition

10 Burial 20 Cremation 30 Removal from State
40 Donation 50 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Daisy Church Cem.

Date

7/31/97

20c. Location - City or Town, State

Woodbine, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SNOWDEN FUNERAL HOME, P.A.
ROCKVILLE, MD 20850

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hemorrhage. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Metastatic lung cancer*
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy performed?

10 Yes 20 No

24b. Were autopsy findings available prior to completion of cause of death?

10 Yes 20 No

25. Was case referred to medical examiner?

10 Yes 20 No

26. Place of Death (Check only one)

Hospital: 10 Inpatient 20 ER/Outpatient 30 DOA

Other:

40 Nursing Home 50 Residence 60 Other (Specify)

27. Manner of Death

10 Natural 50 Pending Investigation
20 Accident 60 Could not be determined
30 Suicide 40 Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

10 Yes 20 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D09834

29d. Date signed (Month, Day, Year)

7/24/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BARRY ROSENBAUM 3720 FARRAGUT AVE. KENSINGTON, MD 20895

31. Date filed (Month, Day, Year)

JUL 31 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21268-0760

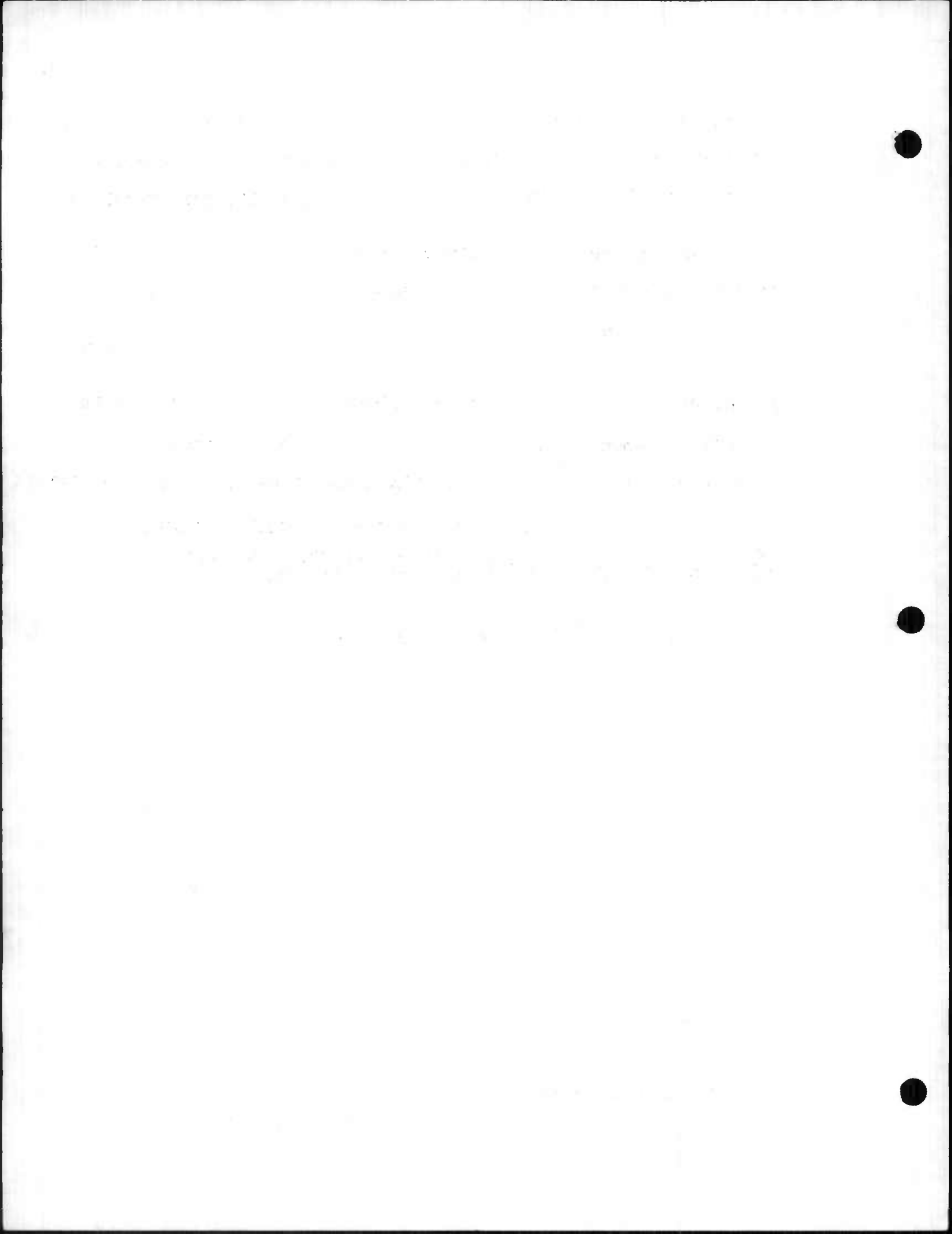
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 25375

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Luciano Perez

2. Date of Death

Month Day Year
July 28, 1997

3. Time of Death

2:50 AM

Funeral
Director

4e. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

5. Social Security Number

217-72-1002

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 27, 1918

9. Birthplace (State or Foreign Country)

Dominican Republic

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11605 Lockwood Drive #T4

10f. Zip Code

20904

10g. Citizen of What Country?

Dominican Republic

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☒ Yes 2 ☐ No Specify:
Dominican Republican

14. Race - American Indian, Black, White, etc.

Specify:
White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Dishwasher

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

Jalito Perez

18. Mother's Name (First, Middle, Maiden Surname)

Encarnacion De la Rosa

19a. Informant's Name/Relationship (Type, Print)

Danol J. Perez

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

812 West Side Drive Gaithersburg, Maryland 20878

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

7/29/97

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

Anchew Cole

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure

Due to (or as a consequence of):

2 Days

b. Aspiration Pneumonia

Due to (or as a consequence of):

2 Days

c. Cardiac Failure

Due to (or as a consequence of):

1

d. Cirrhosis Liver with Ascites

3 Months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cholecystitis, Pancreatitis

Malnutrition

Alcoholism, Emphysema

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Vivek C. Vaid

29c. License number

D 17843

29d. Date signed (Month, Day, Year)

July 28, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vivek C. Vaid, M.D. 3311 Toledo Terrace #B103 Hyattsville, Maryland 20782

31. Date filed (Month, Day, Year)

JUL 30 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

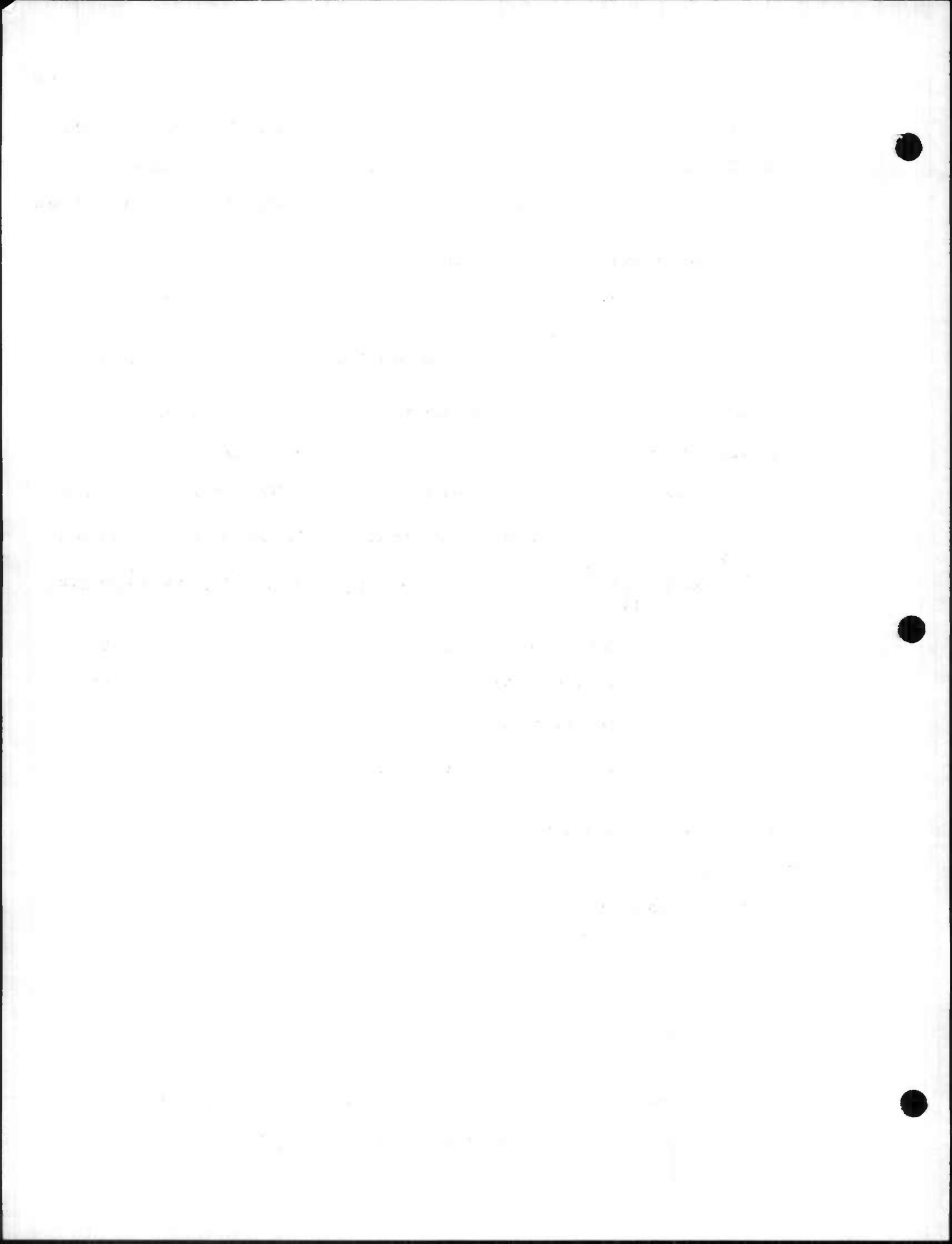
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

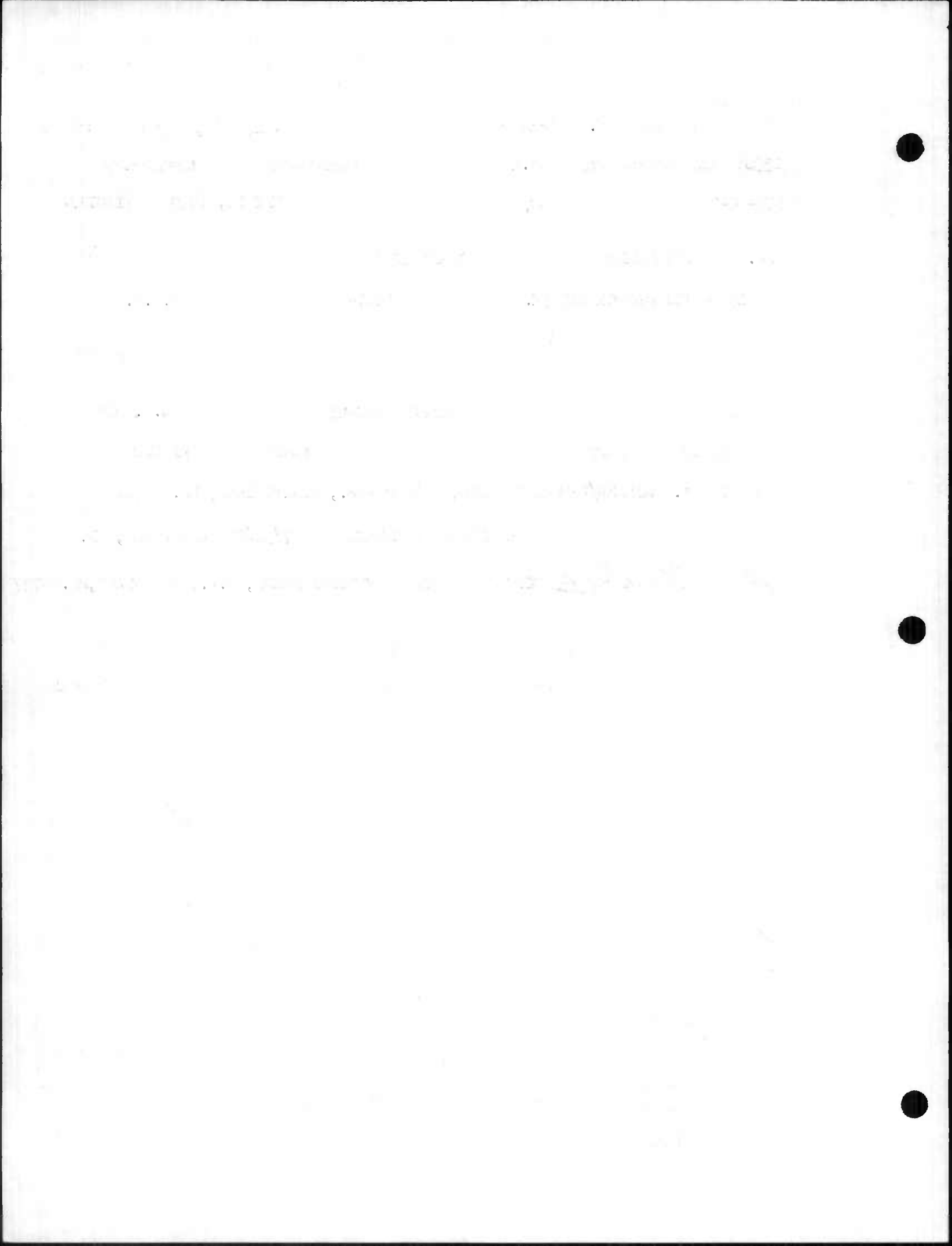
State of Maryland / Department of Health and Mental Hygiene

97 25376

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedant's Name (First, Middle, Last) Bertha Y. Patterson | | | | 2. Date of Death Month July Day 26 Year 1997 | | 3. Time of Death 8:59 Am | |
| | 4a. Facility Name (If not institution, give street and number) 13304 Kilmarnock Way Apt.K | | | | 4b. City, Town, or Location of Death Germantown | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 579-40-7266 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 67 Yrs. | | 8. Date of Birth (Month, Day, Year) MAY 16, 1930 | |
| | 9. Birthplace (State or Foreign Country) VIRGINIA | | 10a. State MD. | | 10b. County MONTGOMERY | | 10c. City, Town or Location GERMANTOWN | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 13304 KILMARNOCK WAY #K. | | 10f. Zip Code 20874 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | |
| Physician /Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CIVIL SERVANT | | 16b. Kind of Business/Industry U.S. MINT | | 17. Father's Name (First, Middle, Last) EDWARD SMITH | |
| | 18. Mother's Name (First, Middle, Maiden Surname) ANGIE BARRET | | 19a. Informant's Name/Relationship (Type, Print) SHERRIE A. MILLER/DAUGHTER | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6207 42nd AVE., HYATTSVILLE, MD. 20781 | | 20e. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| Physician /Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place) CHAMBERS CREMATORY | | 20c. Date 7/31/97 | | 20d. Location - City or Town, State RIVERDALE, MD. | | 21. Signature of Funeral Service Licensee <i>W.W. Chambers</i> MO0091 | |
| | 22. Name and Address of Facility CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Hypertension Due to (or as a consequence of): b. Hypercholesterolemia Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death Years Years | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| Division of Vital Records, P.O. Box 68760, | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form. | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | |
| | 29b. Signature and title of certifier <i>[Signature]</i> MD | | 29c. License number D44513 | | 29d. Date signed (Month, Day, Year) JULY 28, 1997 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SANG-KYUNE LEE, MD 15201 SHADY GROVE RD #202 Rockville, MD 20850 | |
| State Registrar | 31. Date filed (Month, Day, Year) JUL 30 1997 | | 32. Registrar's Signature <i>Julia Davidson-Randall</i> | | 33. Date of Death (Month, Day, Year) JULY 26, 1997 | | 34. Time of Death 8:59 AM | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25377

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | |
|---|--|--|---|--|---|---|--|--|--|--|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) William Allen Pippin | | | | 2. Date of Death Month Day Year August 3, 1997 | | 3. Time of Death 6:00 am | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) 510 St. Martin's Lane | | | | 4b. City, Town, or Location of Death Severna Park | | 4c. County of Death Anne Arundel | | | | | | | | | |
| Funeral Director | 5. Social Security Number 421-14-9089 | | 8. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 74 Yrs. | | 6. Date of Birth (Month, Day, Year) Mar 24, 1923 | | 9. Birthplace (State or Foreign Country) Florida | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County Anne Arundel | | 10c. City, Town or Location Severna Park | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| | 10e. Street and Number 510 St. Martin's Lane | | | | 10f. Zip Code 21146 | | 10g. Citizen of What Country? USA | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collega (14 or 5+) 2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) U.S. Navy, Retired | | | 16b. Kind of Business/Industry U.S. Navy | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Bascom Pippin | | | | 18. Mother's Name (First, Middle, Maiden Surname) Ola Duncan | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Patricia Dudley/daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 510 St. Martin's Lane, Severna Park, MD 21146 | | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MD Veterans Cemetery | | Date Aug 6 1997 | | 20c. Location - City or Town, State Crownsville, MD | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee Robert S. B. | | | | 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146 | | | | | | | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Metastatic Hepatocellular Carcinoma Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | | | Approximate Interval Between Onset and Death 2 weeks | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | 29b. Signature and title of Certifier [Signature] | | 29c. License number 031557 | | 29d. Date signed (Month, Day, Year) August 4, 1997 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Russell A. DeLuca, MD, 1600 S. Crain Highway, Suite 602, Annapolis, MD 21406 | | | | | | | | | | 31. Date filed (Month, Day, Year) AUG 05 1997 | | 32. Registrar's Signature [Signature] | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25378

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|--|--|---|--|---|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JAMES W. PARKER | | | | 2. Date of Death Month July Day 29 Year 1997 | | 3. Time of Death 01:20 AM | |
| | 4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center | | | | 4b. City, Town, or Location of Death Annapolis | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 214-05-1907 | | 6. Sex 1 M 2 F | 7. Age (In yrs. last birthday) 79 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 8-7-17 | 9. Birthplace (State or Foreign Country) MARYLAND |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MARYLAND | 10b. County Anne Arundel | 10c. City, Town or Location Annapolis | | | 10d. Inside City Limits 1 Yes 2 No | | |
| | 10e. Street and Number 1967 Forest Drive | | | 10f. Zip Code 21401 | | 10g. Citizen of What Country? USA | | |
| | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TRUCK DRIVER | | | 16b. Kind of Business/Industry S. Kotzin Co. | | |
| | 17. Father's Name (First, Middle, Last) Archie Parker | | | | 18. Mother's Name (First, Middle, Maiden Surname) Carrie Jackson | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Shirley Clark (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21401 612 Green Brier Lane Annapolis Md. | | | |
| | 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Hillcrest Mem PK | | Date 8/1/97 | | 20c. Location - City or Town, State Annapolis, Maryland | |
| | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility House of Hick F/H 1922 Forest Drive Annapolis, Md. | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SEPTIC SHOCK Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 1 Week | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Insulin Dependent Diabetes Mellitus | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown | | | | 24a. Was an autopsy performed? 1 Yes 2 No | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No | | | | | | | |
| | 25. Was case referred to medical examiner? 1 Yes 2 No | | 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) | | | | | |
| | 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury et Work? 1 Yes 2 No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| State Registrar | 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier Peter F. Verkouw MD | | | | 29c. License number D11653 | | 29d. Date signed (Month, Day, Year) July 29, 1997 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peter F. Verkouw MD 2003 MEDICAL PARKWAY, Annapolis, MD 21401 | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 01 1997 | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

97-4217-031

wlc

VERA SCOTT

PAR

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25379

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) VERA SCOTT PARKS | | | | 2. Date of Death Month Day Year July 29, 1997 | | 3. Time of Death 0755a | |
| 4a. Facility Name (If not institution, give street and number) SUBURBAN HOSPITAL | | | | 4b. City, Town, or Location of Death BETHESDA | | 4c. County of Death MONTGOMERY | |
| 5. Social Security Number 435-48-0035 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 65 Yrs. | | 8. Date of Birth (Month, Day, Year) Oct. 27, 1931 | |
| 9. Birthplace (State or Foreign Country) Louisiana | | 10a. State MD | | 10b. County Montgomery | | 10c. City, Town or Location Rockville | |
| 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 13604 Dowlais Drive | | 10f. Zip Code 20853 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Technician | | 16b. Kind of Business/Industry U.S. Government | | | |
| 17. Father's Name (First, Middle, Last) Henry Scott | | | | 18. Mother's Name (First, Middle, Maiden Surname) Agnes Jackson | | | |
| 19a. Informant's Name/Relationship (Type, Print) Eldridge Parks Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13604 Dowlais Dr., Rockville, MD. 20853 | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven | | 20c. Location - City or Town, State 8-2-97 Silver Spring, MD | | | |
| 21. Signature of Funeral Service Licensee J. P. Marshall | | 22. Name and Address of Facility Marshall's Funeral Home, Inc. 4217 9th Street N.W., Washington, DC 20011 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | | | | 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 7-29-97 | | 28b. Time of Injury 06 50 M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred Driver - Auto - Auto Collision RT 28 | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) Roadway | | | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier David K. Fowler | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) July 30, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David K. Fowler 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 04 1997 | | 32. Registrar's Signature John Andrew Randall | | | | | |

State
Registrar

1988 12 20

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 25380**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Erskine A. Pruitt | | | | 2. Date of Death Month 08 - Day 01 - Year 97 | | 3. Time of Death 8:03 A.M. | |
| 4a. Facility Name (If not institution, give street and number) Prince George's Hospital | | | | 4b. City, Town, or Location of Death Cheverly | | 4c. County of Death Prince George's | |
| 5. Social Security Number 579-62-0847 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 52 Yrs. | | 8. Date of Birth (Month, Day, Year) 08-05-44 | |
| 9. Birthplace (State or Foreign Country) South Carolina | | 10a. State Maryland | | 10b. County Prince George's | | 10c. City, Town or Location Hyattsville | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 2103 Vermont Avenue | | 10f. Zip Code 20785 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Printer | | 16b. Kind of Business/Industry Government | | 17. Father's Name (First, Middle, Last) Erskine Pruitt | |
| 18. Mother's Name (First, Middle, Maiden Surname) Mary Elizabeth Stevenson | | 19a. Informant's Name/Relationship (Type, Print) Helen E. Pruitt/ Wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2103 Vermont Ave., Hyattsville, Maryland 20785 | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cemetery 1997 | | 20c. Location - City or Town, State Cheltenham, Maryland | | 21. Signature of Funeral Service Licensee Nancy A. Perante | | 22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Rd., Landover Maryland 20785 | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last a. CARDIO PULMONARY ARREST MINUTES Due to (or as a consequence of): b. CORONARY ARTERY DISEASE YEARS Due to (or as a consequence of): c. DIABETES MELLITUS YEARS Due to (or as a consequence of): d. SEPTIC SYNDROME DAYS | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHOLECYSTITIS MULTIPLE CEREBRAL INFARCTIONS RENAL INSUFFICIENCY | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | |
| 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier [Signature] | |
| 29c. License number D46285 | | 29d. Date signed (Month, Day, Year) AUGUST 1, 1997 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR Paul Bone 8700 Central Ave Landover, MD 20785 | | 31. Date filed (Month, Day, Year) AUG 05 1997 | |
| 32. Registrar's Signature [Signature] | | 33. State Registrar | | 34. State Registrar | | 35. State Registrar | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25381

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) James R. Riley, Sr. | | | | 2. Date of Death Month August Day 10 Year 1997 | | 3. Time of Death 7:44 AM | |
| | 4a. Facility Name (If not institution, give street and number) Harford Memorial Hospital | | | | 4b. City, Town, or Location of Death Havre de Grace | | 4c. County of Death Harford | |
| Funeral Director | 5. Social Security Number 242-24-5343 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 70 Yrs. | | 8. Date of Birth (Month, Day, Year) December 15, 1926 North Carolina | |
| | 10a. State Maryland | | 10b. County Cecil | | 10c. City, Town or Location Conowingo | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Funeral Director | 10e. Street and Number 131 Rock Springs Rd | | | | 10f. Zip Code 21918 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Unknown | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) 6 Elementary/Secondary (0-12) College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Assembler | | 18b. Kind of Business/Industry Automotive | |
| | 17. Father's Name (First, Middle, Last) Jessie Riley | | | | 18. Mother's Name (First, Middle, Maiden Surname) Florence Greenhouse | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Margaret Riley/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 131 Rock Springs Rd Conowingo, Maryland 21918 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Conowingo Baptist | | 20c. Location - City or Town, State August 13, 1997 Conowingo | | | |
| | 21. Signature of Funeral Service Licensee <i>Richard L. Goodie</i> | | | | 22. Name and Address of Facility R. T. Foard Funeral Home 111 S. Queen St Rising Sun, MD 21911 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiac arrhythmias ? Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus Emphysema Chronic obstructive Pul. Disease | | | | | | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier <i>Beig MIRZA A-BAG MD</i> | | | | 29c. License number D43115 | | 29d. Date signed (Month, Day, Year) 8-10-97 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 615 S. Union Ave Havre DE Grace, MD | | | | | | | |
| | 31. Date filed (Month, Day, Year) AUG 11 1997 | | | | 32. Registrar's Signature <i>Julia Davidson-Pondale</i> | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

TOM RUNYON

State of Maryland / Department of Health and Mental Hygiene 97 25382

Item: 8 per FH G-750 8/27/97 dh
ASP Items: 23a part 1, 27, 28a-f per MEO G-750 8/26/97 dh Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Thomas Scott Runyon | | | | 2. Date of Death Month JULY Day 27 Year 1997 | | 3. Time of Death 1335 P | |
| | 4a. Facility Name (If not institution, give street and number) 11812 DANIEL DRIVE | | | | 4b. City, Town, or Location of Death RAWLINGS | | 4c. County of Death ALLEGANY | |
| Funeral Director | 5. Social Security Number 153-62-3999 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 35 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Jan. 30, 1962 | |
| | 9. Birthplace (State or Foreign Country) New Jersey | | | | | | | |
| Usual Residence of Decedent | | | | | | | | |
| 10a. State New Jersey | | 10b. County Warren | | 10c. City, Town or Location Buttzville | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10a. Street and Number 3 Mill Street, Box 101 | | | | 10f. Zip Code 07829 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1979-1983 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collage (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner | | 16b. Kind of Business/Industry Roofing & Siding | | |
| 17. Father's Name (First, Middle, Last) Thomas H. Runyon | | | | 18. Mother's Name (First, Middle, Maiden Surname) Irene Cote | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Thomas H. Runyon (father) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Box 101, Buttzville, NJ 07829 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory | | Date 7-29-97 | | 20c. Location - City or Town, State Beltsville, Maryland | | |
| 21. Signature of Funeral Service Licensee Ellen L. Rapp | | | | 22. Name and Address of Facility Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910 | | | | |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. HYPERTHERMIA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE | | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) 7/27/97 | | 28b. Time of Injury 1:30 P M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred motorcycle race |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) motorcycle trail | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) Track, Allegany County, Md. | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Stephen S. Radentz, MD | | | | | | |
| | | 29c. License number O.C.M.E | | 29d. Date signed (Month, Day, Year) JULY 28, 1997 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 30 1997 Registrar's Signature John Davidson-Randall | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25383

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jewell E. Roberts

2. Date of Death

Month
JulyDay
27,Year
1997

3. Time of Death

7:30 PM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

243-30-3073

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 24, 1920

9. Birthplace (State or Foreign Country)

Alabama

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☒ Yes ☐ No

10a. Street and Number

8505 Springvale Road, Apt. 107

10f. Zip Code

20910

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Vachel A. Pollard

18. Mother's Name (First, Middle, Maiden Surname)

Lillie Mae Akins

19a. Informant's Name/Relationship (Type, Print)

James W. Roberts, III

Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1312 Mistyvale Street, Herndon, Virginia 20170

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metropolitan Crematory

Date

7/28/97

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

William L. Byrd

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.
500 University Blvd.W. Silver Spring, MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

RESPIRATORY FAILURE

Due to (or as a consequence of):

b.

CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

c.

SARCOIDOSIS

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

Hours

Hours

YEARS

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

INSULIN DEPENDENT DIABETES MELLITUS WITH RETINOPATHY

CHRONIC KIDNEY DISEASE

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural
☐ Accident
☐ Suicide
☐ Homicide
☐ Pending investigation
☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

Robert J. Ginsberg MD

29c. License number

D25344

29d. Date signed (Month, Day, Year)

7/28/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ROBERT J. GINSBERG, MD 2415 MUSGROVE RD #209 SILVER SPRING, MD 20904

31. Date filed (Month, Day, Year)

JUL 30 1997

32. Registrar's Signature

John Davidson-Rendell

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25384

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Elizabeth B. Rigglesman | | | | 2. Date of Death Month Day Year July 25, 1997 | | 3. Time of Death 2:33 PM | |
| | 4a. Facility Name (If not institution, give street and number) Holy Cross Hospital | | | | 4b. City, Town, or Location of Death Silver Spring | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 215-80-6087 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 75 Yrs. | | 8. Date of Birth (Month, Day, Year) Oct. 29, 1921 | |
| | 9. Birthplace (State or Foreign Country) West Virginia | | 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Silver Spring | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 1400 Fenwick Lane, #604 | | 10f. Zip Code 20910 | | 10g. Citizen of What Country? United States | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | | | |
| | 17. Father's Name (First, Middle, Last) George Hall | | | | 18. Mother's Name (First, Middle, Maiden Surname) Barbara Ellen Landis | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Ellen L. Hall Niece | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 106 Goldenrod Drive, Charles Town, WV 25414 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Cemetery | | 20c. Location - City or Town, State 7-30-97 Frederick, Maryland | | | |
| | 21. Signature of Funeral Service Licensee Ellen L. Rapp | | | | 22. Name and Address of Facility Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910 | | | |
| | 23a. Pertinent Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. acute myocardial infarction Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | |
| | Approximate Interval Between Onset and Death 5 days | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier Barbara Ellen Landis | | | | 29c. License number D09834 | | 29d. Date signed (Month, Day, Year) 7/26/97 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) BARRY ROSENDAUM 3720 FARRAGUT AVE KEANSINGTON, MD 20895 | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 28 1997 | | 32. Registrar's Signature John Davidson-Rendell | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25385

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) GRACE LORRAINE REISE
2. Date of Death Month Day Year July 24, 1997
3. Time of Death 12:59 A.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number) Suburban Hospital
4b. City, Town, or Location of Death Bethesda
4c. County of Death Montgomery
5. Social Security Number 387-24-1964
6. Sex 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday) 70 Yrs.
8. Date of Birth (Month, Day, Year) June 7, 1927
9. Birthplace (State or Foreign Country) Canada

Usual Residence of Decedent
10a. State Maryland
10b. County Montgomery
10c. City, Town or Location Ashton
10d. Inside City Limits 1 ☒ Yes 2 ☐ No

10e. Street and Number 17935 Pond Road
10f. Zip Code 20861
10g. Citizen of What Country? United States

11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Social Worker
16b. Kind of Business/Industry Social Work

17. Father's Name (First, Middle, Last) Ira A. Johnson
18. Mother's Name (First, Middle, Maiden Surname) Brunhilda Rose Mueller

19a. Informant's Name/Relationship (Type, Print) William R. Reise - Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17935 Pond Road, Ashton, Maryland 20861

20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place) Norbeck Memorial Park
20c. Location - City or Town, State 7-28-97 Olney, Maryland

21. Signature of Funeral Service Licensee
22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904

23. Part I. Enter the disease, or diseases, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. (List only one cause on each line.)

Immediate Cause (Final disease or condition resulting in death) a. Acute Cancer Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one) Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☒ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier Albert S. Suen M.D.
29c. License number 038682
29d. Date signed (Month, Day, Year) July 24 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10215 Fernwood Dr #405 Bethesda Maryland 20817

31. Date filed (Month, Day, Year) JUL 29 1997
32. Registrar's Signature Lisa Davidson-Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

12

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25386

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LYDIA

REED

2. Date of Death

Month

Day

Year

3. Time of Death

11:55pm

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

213-32-4492

6. Sex

1 ☐ M ☒ F

7. Age (in yrs. last birthday)

60

8. Date of Birth (Month, Day, Year)

11-12-1936

9. Birthplace (State or Foreign Country)

TENNESSEE

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

MILLERSVILLE

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

787 OAKDALE CIRCLE

10f. Zip Code

21108

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

11

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MICROFILM TECHNICIAN

16b. Kind of Business/Industry

WESTINGHOUSE/GRUMAND

17. Father's Name (First, Middle, Last)

JAMES

E.

LONG

18. Mother's Name (First, Middle, Maiden Surname)

ESSIE

D.

DUBREE

19a. Informant's Name/Relationship (Type, Print)

RICHARD A. REED (HUSBAND)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

787 OAKDALE CIRCLE, MILLERSVILLE, MD. 21108

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GLEN HAVEN MEMORIAL PARK

Date

8/4/97

20c. Location - City or Town, State

GLEN BURNIE, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SINGLETON FUNERAL HOME,

1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or blood failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CANCER OF THE LUNG

5 MONTHS

Due to (or as a consequence of):

b. BRAIN METASTASES

5 MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

HOUSE OFFICER, M.D.

29c. License number

D51664

29d. Date signed (Month, Day, Year)

JULY 31, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUDHIR KUMAR AGGARWAL, NORTH ARUNDEL HOSPITAL, 301 HOSPITAL DRIVE, GLEN BURNIE, MD 21061

31. Date filed (Month, Day, Year)

AUG 05 1997

32. Registrar's Signature

John Davidson

State Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25387

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|--|--|--|--|--|---|------------------------------------|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Vincent L Riel | | | | 2. Date of Death Month July Day 29 Year 1997 | | | | 3. Time of Death 1:32PM | |
| | 4a. Facility Name (If not institution, give street and number) Chesapeake Health Care & Rehab Center | | | | 4b. City, Town, or Location of Death Arnold | | | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 094-14-4212 | | 8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 75 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | |
| | 9. Birthplace (State or Foreign Country) New York | | 8. Date of Birth (Month, Day, Year) Sept 28 1921 | | 10a. State MD | | 10b. County Anne Arundel | | 10c. City, Town or Location Annapolis | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 861 Rudder Way | | 10f. Zip Code 21401 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 1941- If Yes, Give Year or Dates: 1945 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+) | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner | | 16b. Kind of Business/Industry Fire Sprinkler Company | | 17. Father's Name (First, Middle, Last) Gregory Riel | | 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth McGovern | | 19a. Informant's Name/Relationship (Type, Print) Shirley A. Riel (Wife) | | |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 861 Rudder Way Annapolis, Maryland 21401 | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cemetery 8/5/97 Arlington, Virginia | | 20c. Location - City or Town, State | | 20d. Date | | |
| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) stroke Due to (or as a consequence of): a. b. c. d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death 2 months | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | |
| 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier | | 29c. License number D38158 | | 29d. Date signed (Month, Day, Year) July 30, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lisa A. DiMarzio, M.D. 2003 Medical Parkway Annapolis, Maryland 21401 | | 31. Data filed (Month, Day, Year) AUG 06 1997 | | 32. Registrar's Signature | | 33. Name and address of person who completed cause of death (Item 23a) (Type, Print) (410-573-1110) | | 34. Name and address of person who completed cause of death (Item 23a) (Type, Print) | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25388

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Brenda Rifino

2. Date of Death

Month
AUGDay
6Year
1997

3. Time of Death

0336

4a. Facility Name (If not institution, give street and number)

ST. Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

056-22-9151

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 20, 1930

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

New York

10b. County

Queens

10c. City, Town or Location

Douglaston

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

68-15 Douglaston Parkway

10f. Zip Code

11362

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

None

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sales

16b. Kind of Business/Industry

Real Estate

17. Father's Name (First, Middle, Last)

James Riley

18. Mother's Name (First, Middle, Maiden Surname)

Mary Ahern

19a. Informant's Name/Relationship (Type, Print)

Mary Rifino (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

351 Warwick Avenue Douglaston, New York 11362

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Long Island National

Date

August 8, 1997

20c. Location - City or Town, State

Pinelawn, New York

21. Signature of Funeral Service Licensee

Michael C. Saffian

22. Name and Address of Facility

Singleton Funeral Home PA
1 Second Avenue S.W. Glen Burnie, Maryland 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Sepsis / Multiple Organ Failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Metastatic Lung Carcinoma

Due to (or as a consequence of):

2 weeks

c. Lower Extremity Arterial Thrombosis

Due to (or as a consequence of):

3 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural
2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide
5 ☐ Pending Investigation
6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael C. Saffian

29c. License number

P10886

29d. Date signed (Month, Day, Year)

8/6/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ST. Agnes Hospital

31. Date filed (Month, Day, Year)

AUG 08 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25389

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

NELLIE H. ROBERTS

2. Date of Death

August 04 Year 1997 0245 AM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Laren Nursing Home

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

5. Social Security Number

578-42-9346

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

(Month, Day, Year)

Oct. 16, 1906

9. Birthplace (State or Foreign Country)

Sunderland, MD

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

8502 Dark Hawk Circle

10f. Zip Code

21045

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

Black

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Self Employed

17. Father's Name (First, Middle, Last)

James A. Holland

18. Mother's Name (First, Middle, Maiden Summa)

Ella Greene

19a. Informant's Name/Relationship (Type, Print)

C. Vernon Gray/Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8502 Dark Hawk Circle Columbia, Md. 21045

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Ft. Lincoln Cemetery

Date

8-9-97

20c. Location - City or Town, State

Brentwood, Md.

21. Signature of Funeral Service Licensee

J. P. Marshall

22. Name and Address of Facility

Marshall's Funeral Home, Inc.

4217 9th St. NW Washington, DC 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Congestive Heart Failure

Approximate Interval Between Onset and Death

years

Due to (or as a consequence of):

Atherosclerotic Cardio Vascular Disease

years

Due to (or as a consequence of):

Hypertension

years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease

Arthritis, Rheumatoid

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

J. E. Seals

29c. License number

K025610

29d. Date signed (Month, Day, Year)

August 5, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jerry E. Seals, M.D. 3460 Ellicott Center Dr. Suite 103 Ellicott City, MD. 21043

31. Date filed (Month, Day, Year)

AUG 07 1997

32. Registrar's Signature

John S. Anderson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25390

Items: 10e, 18, 19b per FH G-751 9/12/97 dh

Certificate of Death

Reg. No.

| | | | | | | | |
|--|--|--|--|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MARJORIE ANN ROGERS | | | 2. Date of Death Month Day Year August 1, 1997 | | 3. Time of Death 10:50 A.M. | |
| | 4e. Facility Name (If not institution, give street and number) GLADYS SPELLMAN SPECIALTY HOSPITAL AND NURSING CENTER | | | 4b. City, Town, or Location of Death CHEVERLY | | 4c. County of Death Prince George's | |
| Funeral Director | 5. Social Security Number 143-24-3737 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 65 | | 8. Date of Birth (Month, Day, Year) Sept. 13, 1931 |
| | 9. Birthplace (State or Foreign Country) Frammingham, Mass. | | 10a. State Maryland | | 10b. County Prince George's | | 10c. City, Town or Location Forestville |
| Usual Residence of Decedent | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 5125 5725 Hil-Mar Drive | | 10f. Zip Code 20747 | |
| 10g. Citizen of What Country? United States | | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. African American | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Executive Director | | 16b. Kind of Business/Industry Private - Phoenix Family Support Network | |
| 17. Father's Name (First, Middle, Last) Jefferson H. Manning | | 18. Mother's Name (First, Middle, Maiden Surname) May Evelyn Nicken Evelyn Tucker | | 19a. Informant's Name/Relationship (Type, Print) Dietra A. Rogers - Daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5125 5725 Hill-Mar Drive, Forestville, MD 20747 | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Lee's Crematory | | 20c. Location - City or Town, State 8/7/97 Clinton, MD | | 21. Signature of Funeral Service Licensee John T. Stewart III | |
| 22. Name and Address of Facility STEWART FUNERAL HOME, Inc. 4001 Benning Road, N.E., Washington, D. C. | | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. RESPIRATORY FAILURE LEUKEMIA | | Approximate Interval Between Onset and Death >3 months >3 months | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. STROKE; ANEMIA | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 8-2-97 | | 28b. Time of Injury M | |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier [Signature] | | 29c. License number D-34525 | | 29d. Date signed (Month, Day, Year) 08-02-97 | |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) C-J. Rao, MD; 4000-Mitchellville Road; #220; Bowie MD-20716 | | 31. Date filed (Month, Day, Year) AUG 06 1997 | | 32. Registrar's Signature [Signature] | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25391

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lacey

2. Date of Death

August 1, 1997

3. Time of Death

1:30 pm

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

231-44-7529

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

58

8. Date of Birth (Month, Day, Year)

12-03-38

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Capital Heights

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4818 Nash Street

10f. Zip Code

20743

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Lacey Gray Rainey

18. Mother's Name (First, Middle, Maiden Surname)

Beatrice Walker

19a. Informant's Name/Relationship (Type, Print)

Geraldine Rainey/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4818 Nash Street Capital Heights, Maryland 20743

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Memorial Park

Date

08/09 1997

20c. Location - City or Town, State

Landover, Maryland

21. Signature of Funeral Service Licensee

Nancy A. Perconte

22. Name and Address of Facility

J.B. Jenkins Funeral Home

7474 Landover Rd. Landover Maryland 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Laryngeal Cancer.
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

David E. Flowers

29c. License number

D34569

29d. Date signed (Month, Day, Year)

8/2/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David E. Flowers MD, 15704 Sycamore Grove Ct. Parkville MD.

31. Date filed (Month, Day, Year)

AUG 05 1997

32. Registrar's Signature

John Anderson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 25392**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

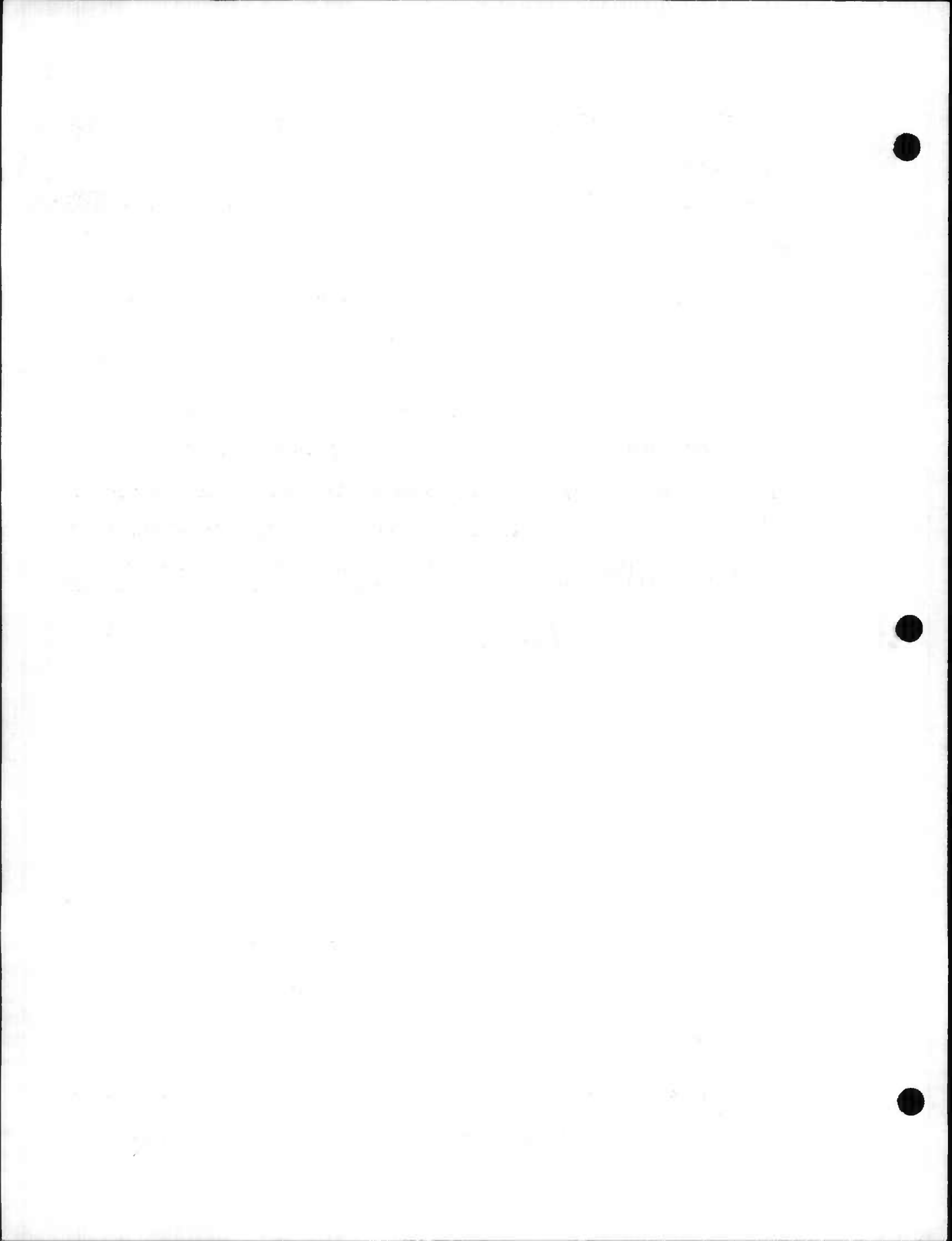
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) VADA VIERS SHEPHERD | | | | 2. Date of Death Month August Day 7 Year 1997 | | 3. Time of Death 7:30 AM | |
| 4a. Facility Name (If not institution, give street and number) 2208 Conowingo Road | | | | 4b. City, Town, or Location of Death Bel Air | | 4c. County of Death Harford | |
| 5. Social Security Number 244-62-3078 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 98 Yrs. | | 8. Date of Birth (Month, Day, Year) Nov. 8, 1898 | |
| 9. Birthplace (State or Foreign Country) North Carolina | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Harford | | 10c. City, Town or Location Bel Air | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 2208 Conowingo Road | | | | 10f. Zip Code 21015 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | | | |
| 17. Father's Name (First, Middle, Last) James (u/k) Viers | | | | 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth (u/k) Bare | | | |
| 19a. Informant's Name/Relationship (Type, Print) Audrey L. Farrington, Niece | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1329 Prospect Mill Road, Bel Air, Maryland 21015 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Ebenezer Cemetery | | 20c. Date 8/11/97 | | 20d. Location - City or Town, State Laurel Springs, NC | |
| 21. Signature of Funeral Service Licensee Howard K. McComas | | | | 22. Name and Address of Facility Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Parkinson's Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 5 years | | | | Approximate Interval Between Onset and Death 5 years | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier DR MD | | | | 29c. License number D34652 | | 29d. Date signed (Month, Day, Year) August 7, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Scott Naswell 2 NORTH AVE BEL AIR MARYLAND 21014 | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 7 1997 | | | | 32. Registrar's Signature John A. Harrell | | | |

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25393

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jewell W. Scott

2. Date of Death

July 17, 1997

3. Time of Death

6:55am

4a. Facility Name (If not institution, give street and number)

HARford Mem. Hospital

4b. City, Town, or Location of Death

Havre de Grace

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

419-48-6389

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct 19, 1924

9. Birthplace (State or Foreign Country)

AL

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Havre de Grace

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4153 U-WAY

10f. Zip Code

21078

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

7+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Peter Webb Sr.

18. Mother's Name (First, Middle, Maiden Surname)

MARY Carter

19a. Informant's Name/Relationship (Type, Print)

George Scott

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4153 U-WAY Havre de Grace, MD

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HARDY Com.

Data

6-2497 LaFayette, AL

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

BEARD Funeral Home
552 Lewis St Havre de Grace, MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarct

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Hypoxic Encephalopathy

Due to (or as a consequence of):

5 day

c. Renal Failure, Acute

Due to (or as a consequence of):

5 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

Amyloidosis

Nephrotic Syndrome

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature] MIRZA ABAIGMD

29c. License number

D43115

29d. Date signed (Month, Day, Year)

7-17-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

State
Registrar

31. Date filed (Month, Day, Year)

JUL 31 1997

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Scott, Jewel Webb 7-17-97 0655

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25394

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|------------------------|--|--|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Marion Bruce Simpson | | | | | | 2. Date of Death Month Day Year August 04, 1997 | | 3. Time of Death 08:00AM | |
| | 4a. Facility Name (If not institution, give street and number) VA Maryland Health Care System | | | | | | 4b. City, Town, or Location of Death Perry Point | | 4c. County of Death Cecil | |
| Funeral Director | 5. Social Security Number 209-20-0060 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 68 Yrs. | | 8. Date of Birth (Month, Day, Year) Sept. 8, 1928 | | 9. Birthplace (State or Foreign Country) Pennsylvania | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State Maryland | | 10b. County Harford | | 10c. City, Town or Location Darlington | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 4041 Conowingo Road, Lot 48, POB 349 | | | | | | 10f. Zip Code 21034 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No WWII If Yes, Give Year or Dates: Korea | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Automotive Mechanic | | | | 16b. Kind of Business/Industry Automotive | | |
| 17. Father's Name (First, Middle, Last) William Wasson Simpson | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Gertrude Kelly | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Norma Lee Simpson-Wife | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4041 Conowingo Rd., Lot 48, POB 349, Darlington, MD 21034 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Harford Memorial Gardens | | | 20c. Location - City or Town, State Aldino, MD | | 20d. Date 8-7-97 | | |
| 21. Signature of Funeral Service Licensee Haley K. McComas | | | | | | 22. Name and Address of Facility Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Liver tumor Due to (or as a consequence of): Approximate Interval Between Onset and Death 2 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic obstructive pulmonary disease | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier Angelo Lucco | | | | | | 29c. License number D 30951 | | 29d. Date signed (Month, Day, Year) August 04, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) ANGELO LUCCO, M.D., Perry Point VA Medical Center, Perry Point, Maryland 21902 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 5 1997 | | | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

MARION B. SIMPSON

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

NAME KNOWN TO PHYSICIAN:
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

1581

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25395

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|---|--|--|--|---|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Nona Mae Sander | | | | 2. Date of Death Month Aug. Day 2, Year 1997 | | 3. Time of Death 7:30 A.M. | | | |
| | 4a. Facility Name (If not institution, give street and number) 1444 Fountain Glen Drive | | | | 4b. City, Town, or Location of Death Bel Air | | 4c. County of Death Harford | | | |
| Funeral Director | 5. Social Security Number 218-22-9482 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 70 Yrs. | | 8. Date of Birth (Month, Day, Year) Jan. 12, 1927 | | | |
| | 9. Birthplace (State or Foreign Country) Pennsylvania | | 10a. State Maryland | | 10b. County Harford | | 10c. City, Town or Location Bel Air | | | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 1532 Murray Place | | 10f. Zip Code 21015 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | College (14 or 5+) College | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | | | | |
| 17. Father's Name (First, Middle, Last) John William Heiser | | | | 18. Mother's Name (First, Middle, Maiden Surname) Betty Aldine Limes | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Susan J. Redman-Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1444 Fountain Glen Drive, Bel Air, MD 21015 | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Bel Air Memorial Gardens | | Date 8-6-97 | | 20c. Location - City or Town, State Bel Air, MD | | | | |
| 21. Signature of Funeral Service Licensee <i>Howard K. McComas III</i> | | | | 22. Name and Address of Facility Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ADENOCARCINOMA of UNKNOWN PRIMARY 1 YEAR | | | | | | | | | Approximate Interval Between Onset and Death | |
| Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>John P. Edwards MD</i> | | 29c. License number D31275 | | 29d. Date signed (Month, Day, Year) AUGUST 4, 1997 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN P. EDWARDS MD | | 31. Date filed (Month, Day, Year) AUG 5 1997 | | 32. Registrar's Signature <i>John P. Edwards</i> | | 33. Address of person who completed cause of death (Item 23a) (Type, Print) 2102 BEL AIR ROAD FAUSTON, MARYLAND 21047 | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25396

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) WALTER GRANT SEXTON | | | | 2. Date of Death Month Day Year August 1, 1997 | | 3. Time of Death 1025a | |
| | 4a. Facility Name (If not institution, give street and number) 856 PRIESTFORD ROAD (FARM) | | | | 4b. City, Town, or Location of Death DARLINGTON | | 4c. County of Death HARFORD | |
| Funeral Director | 5. Social Security Number 241-22-1829 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 76 Yrs. | | 8. Date of Birth (Month, Day, Year) Sept. 30, 1920 | |
| | 9. Birthplace (State or Foreign Country) North Carolina | | 10a. State Maryland | | 10b. County Harford | | 10c. City, Town or Location Darlington | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 856 Priestford Road | | 10f. Zip Code 21034 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1943-46 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farmer | | 16b. Kind of Business/Industry Agriculture | | 17. Father's Name (First, Middle, Last) James Franklin Sexton | |
| | 18. Mother's Name (First, Middle, Maiden Surname) Lalie Elizabeth Wright | | 19e. Informant's Name/Relationship (Type, Print) Ruth Sexton - Wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 856 Priestford Road, Darlington, MD 21034 | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place) Ashe Lawn Cemetery | | 20c. Date 8-5-97 | | 20d. Location - City or Town, State W. Jefferson, NC | | 21. Signature of Funeral Service Licensee Howard K. McComas III | |
| | 22. Name and Address of Facility Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 | | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Multiple injuries a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Accidental <input type="checkbox"/> Could not be determined | |
| | 28a. Date of Injury (Month, Day, Year) 8-1-97 | | 28b. Time of Injury 0900 M | | 28c. Injury at Work? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred Pinned under overturned tractor | |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FARM | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 856 Priestford Rd. Harford | | 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier [Signature] | |
| | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) August 2, 1997 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ambraxon 111 Penn Street, Baltimore, Maryland 21201 | | 31. Date filed (Month, Day, Year) AUG 5 1997 | |
| State Registrar | 32. Signature [Signature] | | 33. Signature [Signature] | | 34. Signature [Signature] | | 35. Signature [Signature] | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25397

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Elsie Haven Schwartz

2. Date of Death

Month Day Year
July 30 1997

3. Time of Death

1:45Am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Harford Memorial Hospital

4b. City, Town, or Location of Death

Havre de Grace

4c. County of Death

Harford

5. Social Security Number

215-68-2678

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

07/21/1912

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Havre de Grace

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

808 Martin Road

10f. Zip Code

21078

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Richard Slack

18. Mother's Name (First, Middle, Maiden Surname)

Bertha Olive Haven

19a. Informant's Name/Relationship (Type, Print)

Jennifer Schwartz- Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

808 Martin Rd. Havre de Grace, MD 21078

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harford Memorial Gardens 8/1/97

Date

20c. Location - City or Town, State

Harford Co., MD

21. Signature of Funeral Service Licensee

Madelyn Mitchell Shaw

22. Name and Address of Facility

Mitchell-Smith Funeral Home

123 S. Washington St. Havre de Grace, MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. - INTRACEREBRAL BLEED

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. -

Due to (or as a consequence of):

c. -

Due to (or as a consequence of):

d. -

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

- Aspiration pneumonia

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ NoHospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending Investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Thomas A. Kink

29c. License number

D42800

29d. Date signed (Month, Day, Year)

7/30/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

E. BROWN MD, LMC 314 S. Union Ave, HMG, Md, 21078

31. Date filed (Month, Day, Year)

JUL 30 1997

32. Registrar's Signature

John Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 25398

Reg. No.

| | | | | | | | | | | | | | | |
|--|---|--|---|--|--|--------------------------------|---|---|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) James A. Simms | | | | 2. Date of Death Month August Day 7 Year 1997 | | 3. Time of Death 1:45 am | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) Veterans Home, Charlotte Hall | | | | 4b. City, Town, or Location of Death Charlotte Hall | | 4c. County of Death St. Mary's | | | | | | | |
| Funeral Director | 5. Social Security Number 217-26-4629 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 84 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth Month, Day, Year February 15, 1913 | 9. Birthplace (State or Foreign Country) Maryland | | | | | | |
| | Usual Residence of Decedent | | | | 10a. State Maryland | | 10b. County Charles | | | | | | | |
| To Be Completed by Funeral Director | 10c. City, Town or Location La Plata | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | |
| | 10e. Street and Number 680 Piscataway Court | | | | 10f. Zip Code 20646 | | 10g. Citizen of What Country? USA | | | | | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Technician | | 16b. Kind of Business/Industry U.S. Gov't | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last) Daniel A. Simms | | | | 18. Mother's Name (First, Middle, Maiden Surname) Alice Reeves | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Annette Simms - Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 680 Piscataway Court, La Plata MD 20646 | | | | | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MD Veterans | | Date August 13, 97 | | 20c. Location - City or Town, State Cheltenham, Maryland | | | | | | | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Adams Funeral Home, Aquasco Maryland 20608 | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | |
| | <table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) a. RESPIRATORY FAILURE Due to (or as a consequence of): b. ASPIRATION PNEUMONIA Due to (or as a consequence of): c. Due to (or as a consequence of): d. </td> <td colspan="6"> Approximate Interval Between Onset and Death a. ~ 30 min b. ~ 30 min to 1 HR. c. d. </td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) a. RESPIRATORY FAILURE Due to (or as a consequence of): b. ASPIRATION PNEUMONIA Due to (or as a consequence of): c. Due to (or as a consequence of): d. | Approximate Interval Between Onset and Death a. ~ 30 min b. ~ 30 min to 1 HR. c. d. | | | | |
| Immediate Cause (Final disease or condition resulting in death) a. RESPIRATORY FAILURE Due to (or as a consequence of): b. ASPIRATION PNEUMONIA Due to (or as a consequence of): c. Due to (or as a consequence of): d. | Approximate Interval Between Onset and Death a. ~ 30 min b. ~ 30 min to 1 HR. c. d. | | | | | | | | | | | | | |

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CARCINOMA PROSTATE W/ METASTASIS | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |

| | | | | | | | | | |
|---|--|---|--|---------------------------------|--|---|--|-----------------------------------|--|
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) August 7, 1997 | | 28b. Time of Injury M | | 28c. Injury at Work? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |

| | | | | | | | | | |
|---|--|--|--|---|--|---------------------------------------|--|--|--|
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier  Ashvinkumar J. Patel MD | | 29c. License number D-44436 | | 29d. Date signed (Month, Day, Year) August 08 1997 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASHVINKUMAR J. PATEL MD 603 POST OFFICE RD WALDORF MD 20602 | | | | | | | | | |

| | | | |
|---|--|--|--|
| 31. Date filed (Month, Day, Year) AUG 12 1997 | | 32. Registrar's Signature  | |
|---|--|--|--|

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Funeral
DirectorPhysician
/Medical
Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25399

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) William E. Scott | | | | 2. Date of Death Month August Day 4 Year 1997 | | 3. Time of Death 0724 | |
| | 4e. Facility Name (If not institution, give street and number) Union Hospital | | | | 4b. City, Town, or Location of Death Elkton | | 4c. County of Death Cecil | |
| Funeral Director | 5. Social Security Number 221-07-4875 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 81 Yrs. | | 8. Date of Birth (Month, Day, Year) Aug. 28, 1915 | |
| | Usual Residence of Decedent | | 9. Birthplace (State or Foreign Country) Wilm., DE | | 10a. State MD | | 10b. County Cecil | |
| To Be Completed by Funeral Director | 10c. City, Town or Location Chesapeake City | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 1263 Randalia Road | | 10f. Zip Code 21915 | |
| | 10g. Citizen of What Country? USA | | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner | | 16b. Kind of Business/Industry Scott TV Service | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 17. Father's Name (First, Middle, Last) Walter J. Scott | | 18. Mother's Name (First, Middle, Maiden Surname) Lucy M. Cook | | 19a. Informant's Name/Relationship (Type, Print) Ellen T. Scott (wife) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1263 Randalia Rd. Chesapeake City, MD 21915 | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Gracelawn Mem. Park | | 20c. Date 8/8/97 | | 20d. Location - City or Town, State New Castle, DE | |
| | 21. Signature of Funeral Service Licensee Nicholas E. Rioldi | | 22. Name and Address of Facility McCrery Funeral Homes, Inc. 3924 Concord Pike, Wilm., DE 19803 | | 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. arrhythmia Due to (or as a consequence of): Coronary artery disease Due to (or as a consequence of): COPD Due to (or as a consequence of): 70 yrs 70 yrs | | Approximate Interval Between Onset and Death | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | |
| | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Joe M. M.D. | | 29c. License number D44716 | | 29d. Date signed (Month, Day, Year) 8/4/97 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 W High St, Elkton MD | | 31. Date filed (Month, Day, Year) AUG 06 1997 | | 32. Registrar's Signature Johanna Davidson-Randall | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

10

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25400

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ralph Curtis Simmons

2. Date of Death

Month

Day

Year

August

4

1997

1910

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Union Hospital

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

5. Social Security Number

216-14-1098

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

October 4, 1914

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10e. State

Md.

10b. County

Cecil

10c. City, Town or Location

Elkton

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

203 Friendship Road

10f. Zip Code

21921

10g. Citizen of What Country?

u.s.a.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates

1934-1938

1938-1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Foreman

16b. Kind of Business/Industry

Conowingo Power

Company

17. Father's Name (First, Middle, Last)

Alfred Simmons

18. Mother's Name (First, Middle, Maiden Surname)

Effie Jones

19a. Informant's Name/Relationship (Type, Print) (wife)

Jessie Blanche Ivy Simmons

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

203 Friendship Rd., Elkton, Md. 21921

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

R. A. Ferris & Co. 87/97

Date

20c. Location - City or Town, State

West Chester, Pa.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gee Funeral Home

259 E. Main Street,

Elkton, Md. 21921

23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus; Chronic Renal Insufficiency

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Monte Makous, MD

29c. License number

D-44783

29d. Date signed (Month, Day, Year)

August 6, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MONTE MAKOUS, MD

111 WEST HIGH STREET, ELKTON MD 21921

31. Date filed (Month, Day, Year)

AUG 08 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

SIMMONS, Ralph

10 x 1 1/4

1. The first part of the document is a list of names and their corresponding addresses. The names are written in a cursive script, and the addresses are written in a more formal, printed style. The list is organized into two columns, with names on the left and addresses on the right.

2. The second part of the document is a list of names and their corresponding addresses. The names are written in a cursive script, and the addresses are written in a more formal, printed style. The list is organized into two columns, with names on the left and addresses on the right.

3. The third part of the document is a list of names and their corresponding addresses. The names are written in a cursive script, and the addresses are written in a more formal, printed style. The list is organized into two columns, with names on the left and addresses on the right.

4. The fourth part of the document is a list of names and their corresponding addresses. The names are written in a cursive script, and the addresses are written in a more formal, printed style. The list is organized into two columns, with names on the left and addresses on the right.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25401
Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|---|--|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) EDWIN FRANK STOBIE | | | | 2. Date of Death Month JUL Day 27 Year 1997 | | | | 3. Time of Death 5:25 PM | |
| | 4a. Facility Name (If not institution, give street and number) NATIONAL NAVAL MEDICAL CENTER | | | | 4b. City, Town, or Location of Death BETHESDA | | | | 4c. County of Death MONTGOMERY | |
| Funeral Director | 5. Social Security Number 173-12-9774 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) Yrs. 75 | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | |
| | 8. Date of Birth (Month, Day, Year) June 22, 1922 | | 9. Birthplace (State or Foreign Country) Pennsylvania | | 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Potomac | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 8612 Red Coat Lane | | 10f. Zip Code 20854 | | 10g. Citizen of What Country? United States | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 1943- If Yes, Give Year or Dates: 1973 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Officer | | 16b. Kind of Business/Industry Military | | | | | |
| | 17. Father's Name (First, Middle, Last) John Stobie | | | | 18. Mother's Name (First, Middle, Maiden Surname) Eva Dickey | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Martha Scherer Stobie/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8612 Red Coat Lane, Potomac, Maryland 20854 | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cemetery | | Date July 31, 1997 | | 20c. Location - City or Town, State Arlington, Virginia | | | |
| | 21. Signature of Funeral Service Licensee Michael P. Kutta M00348 | | 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 W. Montgomery Avenue, Rockville, Maryland 20850-2805 | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MULTI SYSTEM FAILURE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death | | | | | | | |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Physician 2 <input checked="" type="checkbox"/> Medical Examiner | | 29b. Signature and title of certifier John T. Schindler MD | | 29c. License number 18201 (WV) | | 29d. Date signed (Month, Day, Year) 07/28/97 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN T. SCHINDLER, NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600 | | 31. Date filed (Month, Day, Year) JUL 30 1997 | | 32. Registrar's Signature Julia Davidson-Randall | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

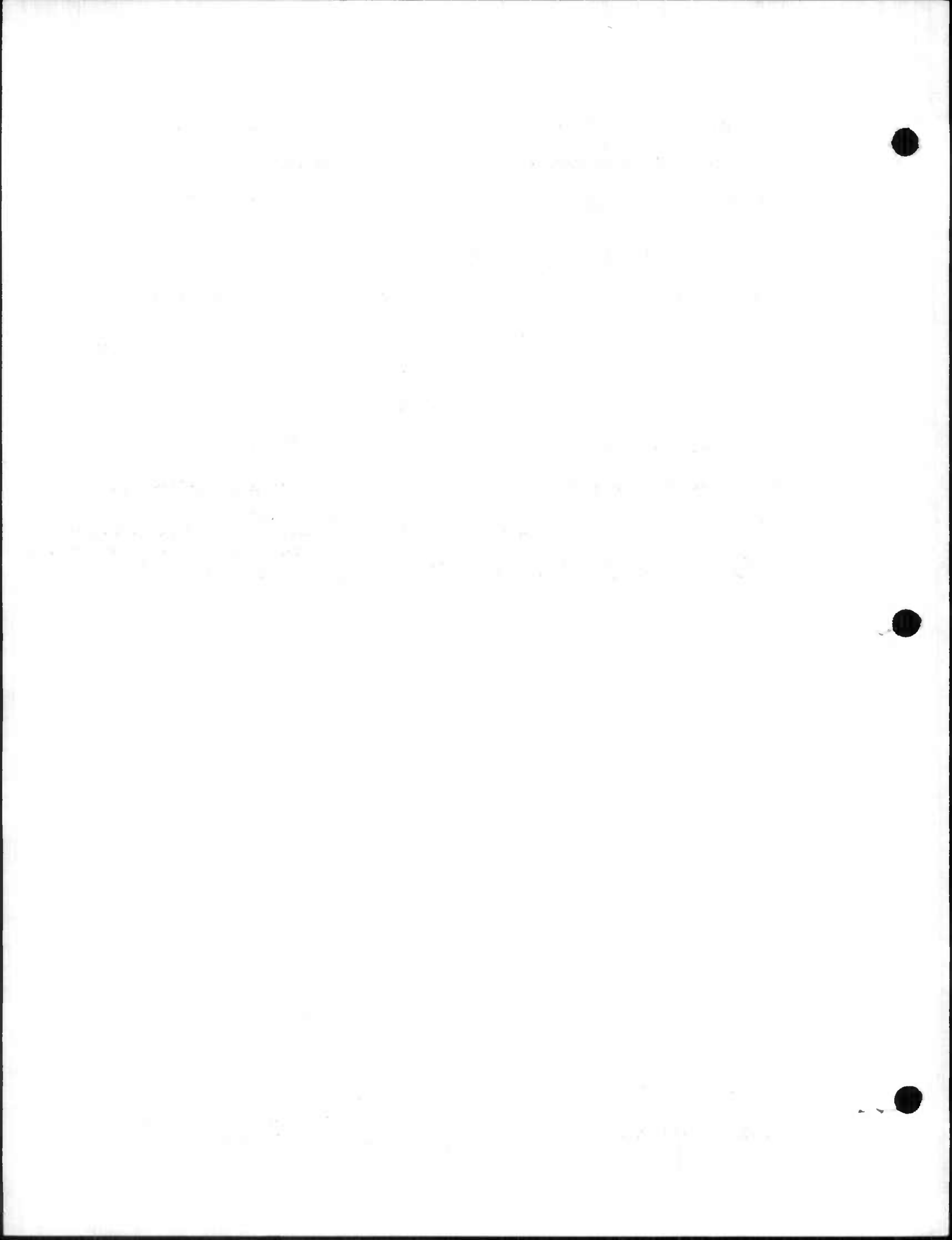
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25402

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

E. Irene Summers

2. Date of Death

Month Day Year
July 30, 1997

3. Time of Death

9:05AM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

212-64-2640

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
February 24, 1910

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2013 Osborn Drive

10f. Zip Code

20910

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12College (1-4 or 5+)
216a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

James Harry Rexrode

18. Mother's Name (First, Middle, Maiden Surname)

Sarah Catherine Kibler

19a. Informant's Name/Relationship (Type, Print)

John C. Summers

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6092 Heatherwood Drive, Alexandria, Virginia 22310

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Chesapeake Crematory

Date

7-31-97

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Carol A. Dehn

22. Name and Address of Facility

Rapp Funeral Services, P.A.
933 Gist Avenue, Silver Spring, Maryland 2091023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Myocardial Infarction

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

5 days

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Paroxysmal Atrial Fibrillation

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Stuart J. Turkovitz MD

29c. License number

D31001

29d. Date signed (Month, Day, Year)

July 30, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Stuart J. Turkovitz M.D.

2500 Greenway Cntr. Dr. #430
Greenbelt, Md. 20770

31. Date filed (Month, Day, Year)

AUG 01 1997

32. Registrar's Signature

John Davidson-Rendell

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25403

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

T. Guilford Smith

2. Date of Death

Month Day Year
July 25, 1997

3. Time of Death

11:40 PM

4a. Facility Name (If not institution, give street and number)

5304 Glenwood Road

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

056-07-8781

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

July 31, 1907

9. Birthplace (State or Foreign Country)

Argentina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5304 Glenwood Road

10f. Zip Code

20814

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: WW II13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Manufacturing Representative Steel & Metals

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Pemberton Smith

18. Mother's Name (First, Middle, Maiden Surname)

Pauline Cruice

19a. Informant's Name/Relationship (Type, Print)

Ruth S. Smith

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

same as 10

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Chesapeake Crematory

Date

7-27-97

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Ellen H. Rapp

22. Name and Address of Facility

Rapp Funeral Services, P. A.
933 Gist Avenue, Silver Spring, MD 2091023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Prostate Cancer

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

5 years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Michael Emmer, M.D.

29c. License number

D 5120

29d. Date signed (Month, Day, Year)

July 26, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Michael Emmer, M. D., 6316 Democracy Blvd., Bethesda, MD 20817-1664

31. Date filed (Month, Day, Year)

JUL 28 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25404

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Edna Simon (AKA Edma Simon)

2. Date of Death

Month Day Year
July 28, 1997

3. Time of Death

10:12AM

4a. Facility Name (If not institution, give street and number)

Mariner Health Care of Silver Spring

4b. City, Town, or Location of Death

Wheaton

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

087-20-0083

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 15, 1904

9. Birthplace (State or Foreign Country)

Lebanon

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Wheaton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

901 Arcola Avenue

10f. Zip Code

20902

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
White15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Elias White

18. Mother's Name (First, Middle, Maiden Surname)

Esma Nader

19a. Informant's Name/Relationship (Type, Print)

Barbara A. Sarvis/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18728 Pintail Lane, Gaithersburg, Maryland 20879

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Prospect Hill Cemetery

Date

August 2, 1997

20c. Location - City or Town, State

Gloversville, New York

21. Signature of Funeral Service Licensee

Barbara J. McMullen Lawrence M00831

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc.
7557 Wisconsin Avenue, Bethesda, Maryland 20814-350123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Intestinal Hemorrhage

Due to (or as a consequence of):

months

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Carcinoma of Colon

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury et
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Barry Rosenbaum

29c. License number

D09834

29d. Date signed (Month, Day, Year)

July 28, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Barry Rosenbaum, M.D. 3720 Farragut Avenue, Kensington, MD 20895

31. Date filed (Month, Day, Year)

AUG 01 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25405

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|--|---|--|--|---|--|--------------------------------|---|--------------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Olga Shipley | | | | 2. Date of Death Month Day Year July 24, 1997 | | | | 3. Time of Death 9:20 AM | |
| | 4a. Facility Name (If not institution, give street and number) 6108 Granby Road | | | | 4b. City, Town, or Location of Death Derwood | | | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 579-12-6776 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 85 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | |
| | 8. Date of Birth (Month, Day, Year) Aug. 10, 1911 | | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State MD | | 10b. County Montgomery | | 10c. City, Town or Location Olney | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 17032 Old Baltimore Road | | 10f. Zip Code 20832 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) housewife | | 16b. Kind of Business/Industry home | | | | |
| 17. Father's Name (First, Middle, Last) James O. Henderson | | | | 18. Mother's Name (First, Middle, Maiden Surname) Ella Hamilton Henderson | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Patricia S. Hart/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17032 Old Baltimore Road, Olney, MD 20832 | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Fr. Lincoln Cemetery | | Date 7/26/97 | | 20c. Location - City or Town, State Brentwood, MD | | | | |
| 21. Signature of Funeral Service Licensee <i>James O. Henderson</i> | | | | 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Atherosclerotic Vascular disease</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate interval between Onset and Death Years | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic obstructive pulmonary disease</i> | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | |
| | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | 26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <i>Assisted Living Home</i> | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier <i>Byrd D. Johnson M.D.</i> | | 29c. License number 0-19042 | | 29d. Date signed (Month, Day, Year) July 25, 1997 | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>BYRD D. JOHNSON M.D. 911 Russell Avenue Gaithersburg, Maryland 20879</i> | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 30 1997 | | 32. Registrar's Signature <i>Julia Davidson-Rendell</i> | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

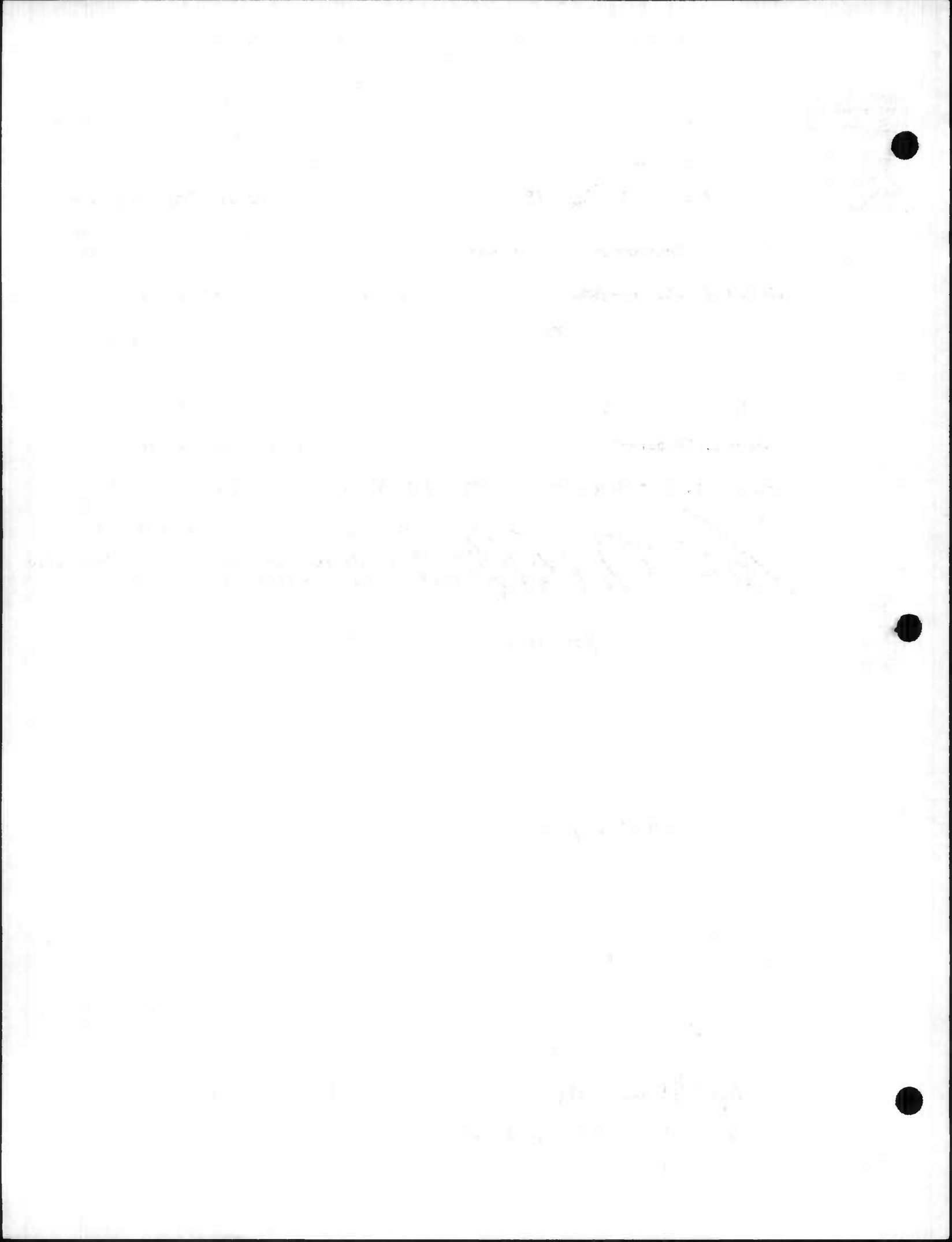
Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

13



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25406

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

| | | | | | |
|--|--|---|--|--|---|
| 1. Decedent's Name (First, Middle, Last) Hans Sethi | | 2. Date of Death Month July Day 28 Year 1997 | | 3. Time of Death 12:10 PM | |
| 4a. Facility Name (If not institution, give street and number) Holy Cross Hospital | | 4b. City, Town, or Location of Death Silver Spring | | 4c. County of Death Montgomery | |
| 5. Social Security Number None | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 25 | 8. Date of Birth (Month, Day, Year) July 3, 1997 | | 9. Birthplace (State or Foreign Country) Maryland |
| Usual Residence of Decedent | | 10c. City, Town or Location Silver Spring | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. State Maryland | 10b. County Montgomery | 10f. Zip Code 20902 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) None | | 16b. Kind of Business/Industry None | |
| 17. Father's Name (First, Middle, Last) M. M. Sethi | | 18. Mother's Name (First, Middle, Maiden Surname) Rachna Sethi | | | |
| 19a. Informant's Name/Relationship (Type, Print) (uncle & aunt) Ashok & Em Sethi | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as 10 | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory | | 20c. Location - City or Town, State 7-29-97 Beltsville, Maryland | |
| 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ARNEA Due to (or as a consequence of): b. HYPOTROPHIC CEPHALY Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d. | | Approximate Interval Between Onset and Death 8 HRS 25 DAYS | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. VENTRICULAR SEPTAL DEFECT, SEIZURES | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier  | | 29c. License number D 20524 | |
| 29d. Date signed (Month, Day, Year) 7/29/97 | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) STEVEN P. WYNNER, MD, HOLY CROSS HOSPITAL, 1500 FOREST GLEN RD, SILVER SPRING, MD 20910 | | | |
| 31. Date filed (Month, Day, Year) JUL 30 1997 | | 32. Registrar's Signature  | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25407

Certificate of Death

Reg. No.

| | | | | | | | | | | | | |
|---|--|--|---------------------------------|--|--|--|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Franklin D. Sech | | | | 2. Date of Death Month July Day 27 Year 1997 | | | | 3. Time of Death 10:00AM | | | |
| | 4a. Facility Name (If not institution, give street and number) Doctors Community Hospital | | | | 4b. City, Town, or Location of Death Lanham | | | | 4c. County of Death Prince George's | | | |
| Funeral Director | 5. Social Security Number 236-58-0718 | | 6. Sex 1 M 2 F | | 7. Age (In yrs. last birthday) 59 Yrs. | | 8. Date of Birth (Month, Day, Year) Jan. 27, 1938 | | 9. Birthplace (State or Foreign Country) West Virginia | | | |
| | 10a. State Maryland | | | | 10b. County Prince George's | | | | 10c. City, Town or Location New Carrollton | | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 Yes 2 No | | | | 10e. Street and Number 5501 Karen Elaine Drive #1103 | | | | 10f. Zip Code 20784 | | | |
| | 10g. Citizen of What Country? U.S.A. | | | | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | | | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales | | | | 16b. Kind of Business/Industry Shoes | | | | 17. Father's Name (First, Middle, Last) John Sech | | | |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Surname) Annie Servik | | | | 19a. Informant's Name/Relationship (Type, Print) Roberta A. Sech | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5501 Karen Elaine Drive #1103 New Carrollton, MD 20784 | | | |
| | 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory | | | | 20c. Location - City or Town, State 7/29/97 Alexandria, Virginia | | | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee John L. Chupak | | | | 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 | | | | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ventricular Fibrillation Due to (or as a consequence of): b. Coronary artery Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown | | | | 24a. Was an autopsy performed? 1 Yes 2 No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 Yes 2 No | | | | 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined | | | |
| | 28a. Date of Injury (Month, Day Year) 28 7 1997 | | | | 28b. Time of Injury M | | | | 28c. Injury at Work? 1 Yes 2 No | | | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier John L. Chupak | | | | 29c. License number D 25071 | | | |
| To Be Completed by Physician/Medical Examiner | 29d. Date signed (Month, Day, Year) 7/27/97 | | | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Don H. Yablonsky, MD 7404 Executive Pl. #502, Bethesda, MD 20706 | | | | 31. Date filed (Month, Day, Year) 7/27/97 | | | |
| | 32. Registrar's Signature John L. Chupak | | | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25408

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|---|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Marian Lowen Schlackman | | | | 2. Date of Death Month July Day 26 Year 1997 | | 3. Time of Death 6:10am | |
| | 4a. Facility Name (If not institution, give street and number) Manor Care Silver Spring | | | | 4b. City, Town, or Location of Death Silver Spring | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 577-09-1913 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 80 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Sept. 24, 1916 | 9. Birthplace (State or Foreign Country) Washington DC |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County Montgomery | | 10c. City, Town or Location Silver Spring | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 2501 Musgrove Road | | | | 10f. Zip Code 20904 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Renewal Clerk | | | 16b. Kind of Business/Industry Broadcast Bureau FCC | |
| 17. Father's Name (First, Middle, Last) Charles Marks | | | | 18. Mother's Name (First, Middle, Maiden Surname) Esther Herman | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Judy Meyer-Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7813 Worthing Ct. Alexandria, VA 22315 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Lebanon Cemetery | | Date 7/29/97 | | 20c. Location - City or Town, State Adelphi, MD |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Edward Sagel Funeral Direction 1091 Rockville Pike Rockville MD 20852 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | e. Dementia Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death 5 yrs |
| | | | | b. Acute renal failure Due to (or as a consequence of): | | | | 1 month |
| | | | | c. Due to (or as a consequence of): | | | | |
| | | | | d. Due to (or as a consequence of): | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number 043237 | | 29d. Date signed (Month, Day, Year) 7-28-97 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Armstrong mo 14201 Laurel Pl. Dr. #102 Laurel mo 20707 | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 29 1997 | | | | 32. Registrar's Signature  | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

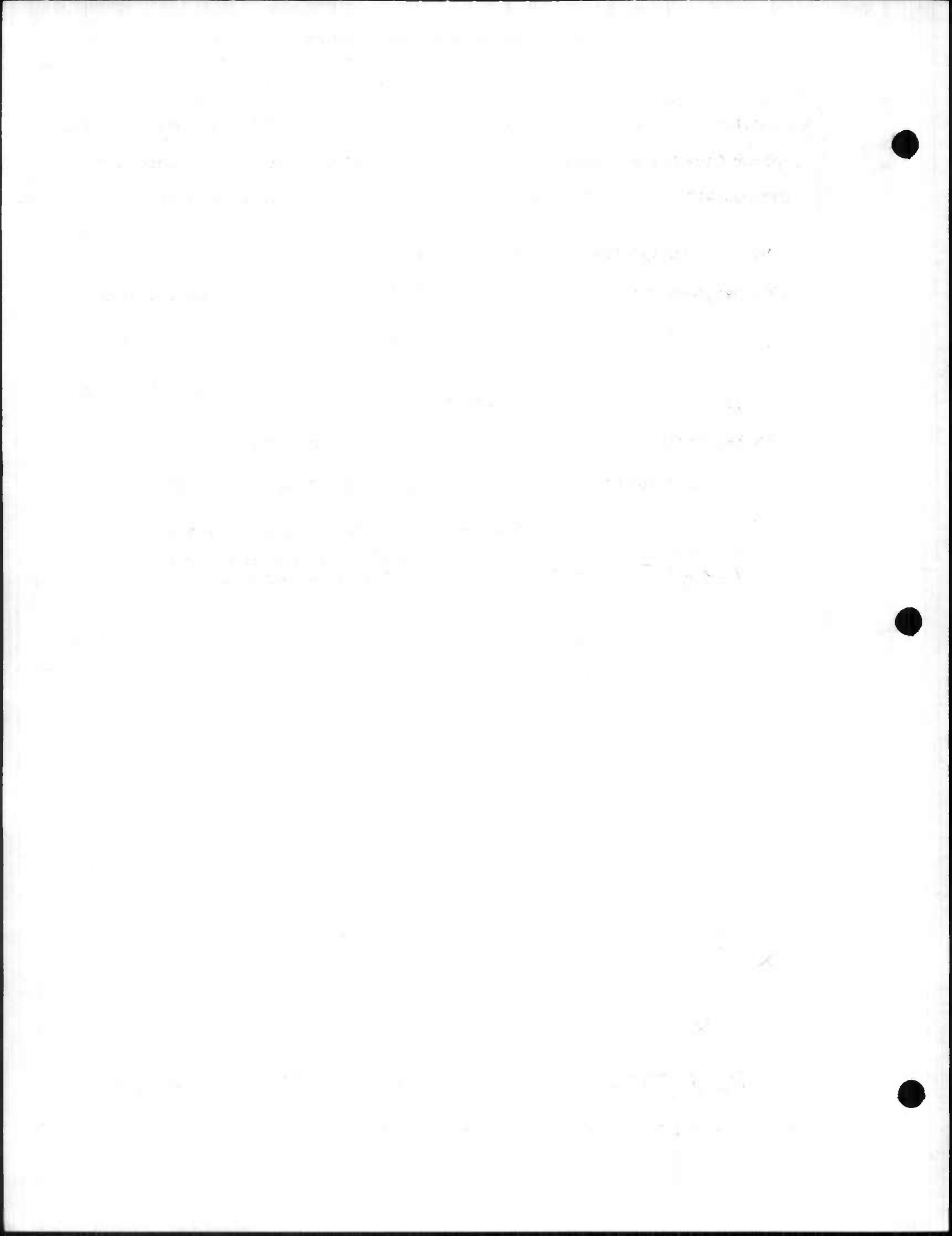
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

20

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25409

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|--|--|---|---|---|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Immacolata Sbarra | | | | 2. Date of Death Month July Day 20 Year 1997 | | 3. Time of Death 9:00 AM | |
| | 4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital | | | | 4b. City, Town, or Location of Death Takoma Park | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 099-03-9073 | | 6. Sex 1 M 2 F | 7. Age (In yrs. last birthday) 86 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) March 2, 1911 | |
| | 9. Birthplace (State or Foreign Country) Connecticut | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County Montgomery | | 10c. City, Town or Location Silver Spring | | | 10d. Instda City Limits 1 Yes 2 No |
| | 10e. Street and Number 9727 Mount Pisgah Rd. Apt. #1409 | | | | 10f. Zip Code 20903 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales | | 16b. Kind of Business/Industry Retail | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Alfonso Ferrucci | | | | 18. Mother's Name (First, Middle, Maiden Surname) Theresa DiBiasi | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Elena Italia | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1608 Neeley Rd. Silver Spring, MD 20903 | | | |
| | 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cem. | | Date 9-4-97 | | 20c. Location - City or Town, State Arlington, Va | |
| | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Hines Rinaldi Funeral Home 11800 New Hampshire Ave. Silver Spring, MD 20904 | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Congestive Heart Failure Due to (or as a consequence of): b. Renal Insufficiency Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death Years Years |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Artery Disease | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown |
| | 24a. Was an autopsy performed? 1 Yes 2 No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No |
| | 25. Was case referred to medical examiner? 1 Yes 2 No | | 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | |
| 27. Manner of Death 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 Yes 2 No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number D25009 | | 29d. Date signed (Month, Day, Year) July 30, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr. Pamela Mulshine 11251 Lockwood Dr. Silver Spring, MD 20901 | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 30 1997 | | 32. Registrar's Signature | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

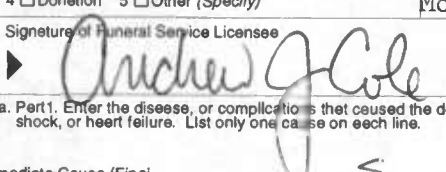
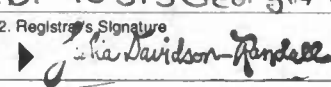
State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25410

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Arthur Donald Sartwell | | | | 2. Date of Death Month July Day 25 Year 1997 | | 3. Time of Death 6:17 PM | |
| | 4a. Facility Name (If not institution, give street and number) Montgomery General Hospital | | | | 4b. City, Town, or Location of Death Olney | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 220-40-6337 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 53 Yrs. | 8. Date of Birth (Month, Day, Year) Aug. 17, 1943 | | 9. Birthplace (State or Foreign Country) Washington, D.C. | |
| | 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Rockville | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 13203 Beaver Terrace | | 10f. Zip Code 20853 | | 10g. Citizen of What Country? U.S.A. | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Civil Engineer | | 16b. Kind of Business/Industry Federal Government | | | | |
| 17. Father's Name (First, Middle, Last) Glen James Sartwell | | | | 18. Mother's Name (First, Middle, Maiden Surname) Virginia Vincent | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Joyce Ann Sartwell | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13203 Beaver Terrace Rockville, Maryland 20853 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Comfort Cemetery | | Date 7/29/97 | | 20c. Location - City or Town, State Alexandria, Virginia | | |
| 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 | | | | | | |
| 23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Sudden Cardiac Death Due to (or as a consequence of): b. Ventricular tachycardia Due to (or as a consequence of): c. CORONARY ARTERY DISEASE Due to (or as a consequence of): d. Hypertension | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | |
| | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner | | 29c. License number D40365 | | | | | | |
| | | 29d. Date signed (Month, Day, Year) July 26, 1997 | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peter J. SABIA, M.D. 10313 Georgia Ave Suite 308 Silver Spring, Md 20902 | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 28 1997 | | 32. Registrar's Signature  | | | | | | |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit notice.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25411

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lorraine Anna Sager

2. Date of Death

Month Day Year
July 28, 1997

3. Time of Death

11:40 A.M.

4a. Facility Name (If not institution, give street and number)

10246 Nolan Drive

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

218-24-2893

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 4, 1919

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10246 Nolan Drive

10f. Zip Code

20850

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Stuart Repass

18. Mother's Name (First, Middle, Maiden Surname)

Helen Asbury

19a. Informant's Name/Relationship (Type, Print)

Barbara A. Moyers/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10218 Nolan Drive, Rockville, Maryland 20850

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parklawn Memorial Park

Date

7/31/97

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DeVol Funeral Home

10 East Deer Park Dr., Gaithersburg, MD. 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Cancer of Kidney

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Years

b. Deep Venous Thrombosis

Due to (or as a consequence of):

1 month

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, Hyperlipidemia, Hiatal Hernia

Arteriosclerosis, Colon Polyps

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

July 29, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Douglas R. Shumaker, M.D., 615 West Montgomery Ave., Rockville, Maryland 20850-3815

State
Registrar

31. Date filed (Month, Day, Year)

JUL 30 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

10

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25412

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jesse H. Stewart

2. Date of Death

Month Day Year
July 23, 1997

3. Time of Death

4:35 PM

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

5. Social Security Number

193-14-7010

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Aug. 27, 1925

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10e. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3376 Chiswick Court #1A

10f. Zip Code

20906

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: WW II13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Defense Intelligence

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

John Clark Stewart

18. Mother's Name (First, Middle, Maiden Surname)

Mary Anna Boltz

19e. Informant's Name/Relationship (Type, Print)

Lynne J. Boileau

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7500 Greenway Center Drive Greenbelt, Maryland 20770

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metropolitan Crematory

Date

7/28/97

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

Kevin Gutowski

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.
500 University Blvd., W., Silver Spring, MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. multiple organ failure

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

3 days

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. septicemia

Due to (or as a consequence of):

3 days

c. gangrene right foot

Due to (or as a consequence of):

2 weeks

d. peripheral vascular disease

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24e. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28e. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Robert L. Fox, M.D.

29c. License number

D 24773

29d. Date signed (Month, Day, Year)

July 26, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert L. Fox, MD 9715 Medical Center Drive, Rockville, Md.

31. Date filed (Month, Day, Year)

JUL 29 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
10+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25413

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES E. SHARPS

2. Date of Death

Month Day Year
JULY 30 1997

3. Time of Death

1845

4a. Facility Name (If not institution, give street and number)

SPA CREEK CENTER

4b. City, Town, or Location of Death

ANNAPOLIS

4c. County of Death

ANNE ARUNDEL

Funeral
Director

5. Social Security Number

219-28-9340

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
DEC. 18 1929

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10e. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

ANNAPOLIS

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2082 FOREST DRIVE

10f. Zip Code

21401

10g. Citizen of What Country?

US

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CONSTRUCTION

16b. Kind of Business/Industry

TALBOT & SONS CONSTRUCTION

17. Father's Name (First, Middle, Last)

GEORGE SHARPS

18. Mother's Name (First, Middle, Maiden Surname)

AGNES WATTS

19a. Informant's Name/Relationship (Type, Print)

ELLA MAE HUNTER (NEICE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

205 B BOXWOOD RD. APT. 108 ANNAPOLIS, MD. 21403

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ANNAPOLIS MEM. GARDENS

Date

20c. Location - City or Town, State

ANNAPOLIS, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

WM. REESE & SONS MORTUARY, P.A.

821 WEST ST. ANNAPOLIS, MD. 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Laryngeal Cancer*

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

7 years.
RSE

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D30701

29d. Date signed (Month, Day, Year)

8/1/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT SCOTT EDEN, MD, 1410 FOREST DR., ANNAPOLIS, MD 21403

31. Date filed (Month, Day, Year)

AUG 04 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25414

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ELEANOR W. STEIMLE

2. Date of Death

Month 8 - Day 1 - Year 97 0730

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Manresa on the Severn

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

218-20-1718

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

Jan. 10, 1906 Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

710 Americana Drive, Apt. 23, Annapolis

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

710 Americana Drive, Apt 23

10f. Zip Code

21403

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Head Receptionist

16b. Kind of Business/Industry

Retail

17. Father's Name (First, Middle, Last)

Francis R. Wadleigh

18. Mother's Name (First, Middle, Maiden Surname)

Mariana Rogers

19a. Informant's Name/Relationship (Type, Print)

Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1551 Ashcroft Lane, Arnold, MD 21012

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Blandford Cemetery

Date

Sept. 97

20c. Location - City or Town, State

Petersburg, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

John M. Taylor Funeral Home, Inc
147 Duke of Gloucester St. Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. ACUTE RESPIRATORY FAILURE SUDDEN

Due to (or as a consequence of):

b. CARCINOMA OF LUNG (LARGE CELL) 1 YR.

Due to (or as a consequence of):

c. & CHRONIC OBSTRUCTIVE PULM. 05 YEARS

Due to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

OSTEOPOROSIS

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending Investigation8 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S.D. KRIMIALS 900 BOSTWICK RD. ANNAPOLIS, MD 21401

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25415

Certificate of Death

Reg. No.

| | | | | | |
|---|---|--|---|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JAMES SPRIGGS | | 2. Date of Death Month 8 Day 3 Year 97 | | 3. Time of Death 1030 |
| | 4a. Facility Name (If not institution, give street and number) Anne ARUNDEL MEDICAL CENTER | | 4b. City, Town, or Location of Death ANNAPOLIS | | 4c. County of Death ANNE ARUNDEL |
| Funeral Director | 5. Social Security Number 214-52-8686 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 47 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) JULY 8 1950 | | 9. Birthplace (State or Foreign Country) MARYLAND | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10c. City, Town or Location | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10a. State MARYLAND | 10b. County ANNE ARUNDEL | 10e. Street and Number 1205 MADISON STREET | | 10f. Zip Code 21403 |
| | 10g. Citizen of What Country? US | | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CARPENTER | | 16b. Kind of Business/Industry ANNAPOLIS FLOORING |
| | 17. Father's Name (First, Middle, Last) WILLIAM S. SPRIGGS SR. | | 18. Mother's Name (First, Middle, Maiden Surname) MARY L. JONES | | |
| | 19a. Informant's Name/Relationship (Type, Print) IRENE HOLLAND (SISTER) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 A BENS DRIVE ANNAPOLIS, MD. 21403 | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY | | 20c. Location - City or Town, State BALTIMORE, MD. |
| | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | 22. Name and Address of Facility WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401 | | |
| | 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | |
| Physician /Medical Examiner | Immediate Cause (Final disease or condition resulting in death) | | a. Cryptococcal cerebritis/meningitis Due to (or as a consequence of): | | Approximate Interval Between Onset and Death 6 weeks Decades |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | b. Alcoholism Due to (or as a consequence of): | | |
| | | | c. Due to (or as a consequence of): | | |
| | | | d. Due to (or as a consequence of): | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier R. Scott Eden, M.D. | | 29c. License number D30701 | | 29d. Date signed (Month, Day, Year) 8/4/97 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R. SCOTT EDEN, M.D., 1410 FOREST DR, ANNAPOLIS, MD 21403 | | | | | |
| 31. Date filed (Month, Day, Year) AUG 06 1997 | | 32. Registrar's Signature <i>[Signature]</i> | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

21012

U.S. DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

June 10, 1937

Dear Sir:

I have the honor to acknowledge the receipt of your letter of June 8, 1937, regarding the matter mentioned therein.

The Bureau is currently reviewing the information submitted and will advise you of the results of its investigation as soon as possible.

Very respectfully,
[Signature]

Special Agent in Charge

U.S. DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

Enclosed for your information are two copies of a report of the Bureau of Plant Industry, dated June 8, 1937, regarding the matter mentioned in your letter.

Very truly yours,
[Signature]

Special Agent in Charge

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Very truly yours,
[Signature]

Special Agent in Charge

Very truly yours,
[Signature]

JUN 10 1937

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

AMEND # 4A, 10E 8-8-97 cms AACO Health

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 25416

Reg. No.

| | | | | | | | | |
|---|--|--|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) HENRY LEVY SOHL, JR. | | | | 2. Date of Death Month Day Year AUGUST 4, 1997 | | 3. Time of Death 11:15 P.M. | |
| | 4a. Facility Name (If not institution, give street and number) 327 ARMORE ROAD 327 ARDMORE ROAD | | | | 4b. City, Town, or Location of Death LINTHICUM | | 4c. County of Death ANNE ARUNDEL | |
| Funeral Director | 5. Social Security Number 212-26-7976 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 68 67 Yrs. | | 8. Date of Birth (Month, Day, Year) JAN. 23, 1930 | |
| | 9. Birthplace (State or Foreign Country) MARYLAND | | 10a. State MARYLAND | | 10b. County ANNE ARUNDEL | | 10c. City, Town or Location LINTHICUM | |
| To Be Completed by Funeral Director | Usual Residence of Decedent 10a. State MARYLAND | | | | 10b. County ANNE ARUNDEL | | 10c. City, Town or Location LINTHICUM | |
| | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number 327 ARMORE ROAD 327 Ardmore Road | | 10f. Zip Code 21090 | |
| To Be Completed by Physician/Medical Examiner | 10g. Citizen of What Country? U.S.A. | | | | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 1947- If Yes, Give Year or Dates: 1950 | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 4 | |
| To Be Completed by Physician/Medical Examiner | 16. Kind of Business/Industry WESTINGHOUSE | | | | 17. Father's Name (First, Middle, Last) HENRY LEVY SOHL, SR. | | 18. Mother's Name (First, Middle, Maiden Surname) STELLA DABROWKA | |
| | 19a. Intendant's Name/Relationship (Type, Print) GERTRUDE HELENE SOHL (WIFE) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 327 ARMORE ROAD, LINTHICUM, MD. 21090 | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MARYLAND VETERANS CEMETERY | | 20c. Location - City or Town, State CROWNSVILLE, MD. | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiac arrest Due to (or as a consequence of): b. Stage IV Pancreatic cancer Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | Approximate Interval Between Onset and Death | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Arterio-sclerotic cardiovascular disease. | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| To Be Completed by Physician/Medical Examiner | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | |
| | 29b. Signature and title of certifier | | | | 29c. License number D 38287 | | 29d. Date signed (Month, Day, Year) 8/5/97 | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST AGNES HEALTH CARE 900 CATON AV. BALTIMORE - MD 21229. | | | | 31. Date filed (Month, Day, Year) AUG 08 1997 | | | |
| | 32. Registrar's Signature | | | | 33. State Registrar AUG 08 1997 | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

REQUEST FOR CORRECTION/AMENDMENT TO DEATH CERTIFICATE

OF HENRY LEVY SOHL, JR.

212-26-7976

DECEDENT

SS #

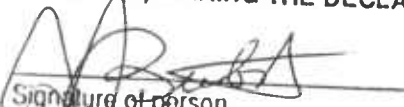
All items on death certificates must be complete and accurate. Please supply the information to be changed in the appropriate space below. Submit it to the Division of Vital Records or Local Health Department in which you registered the original.

SPECIAL INSTRUCTIONS

1. Avoid all abbreviations unless otherwise instructed.
2. Age in years should correspond with date of birth.
3. Do not enter "retired" in response to item 16a "Decedent's Usual Occupation".
4. Check **ONE ITEM ONLY** for marital status.
5. List complete race, not initials. Example: Black, White, etc. Do not enter "U.S.A." for the race of the decedent.

| | | | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH (Month, Day, Year) | | | | 3. TIME OF DEATH | | | | | |
| 4. SOCIAL SECURITY NUMBER | | | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 67 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) | | 8. BIRTHPLACE (State or Foreign Country) | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 327 ARDMORE ROAD | | | | 9b. CITY, TOWN OR LOCATION OF DEATH | | | | 9c. COUNTY OF DEATH | | | | | |
| 10a. STATE | | | | 10b. COUNTY | | | | 10c. CITY, TOWN OR LOCATION | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 327 ARDMORE ROAD | | | | 10f. ZIP CODE | | | | 10g. CITIZEN OF WHAT COUNTRY? | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Divorced 4 <input type="checkbox"/> Widowed | | | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify | | | | 14. RACE - American Indian, Black, White, etc. Specify. | |
| 15. DECEDENT'S EDUCATION Specify only highest grade completed Elementary/Secondary (1-12) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Last) | | | | | | | | | |
| 19a. INFORMANT'S NAME (First, Middle, Last) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 327 ARDMORE ROAD, LINTHICUM, MD. 21090 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | | | DATE | | 20c. LOCATION - City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | |

THE STATEMENTS MADE HEREIN ARE MADE UNDER THE PENALTIES OF PERJURY THAT THE MATTERS AND FACTS CONTAINED HEREIN ARE TRUE TO THE BEST OF THE KNOWLEDGE, INFORMATION, AND BELIEF OF THE INDIVIDUAL(S) MAKING THE DECLARATIONS.


Signature of person
providing information

JAMIE SIEBERT
FUNERAL DIRECTOR

Name, Title
(typed or printed)

AUGUST 7, 1997

Date

IMPORTANT - PLEASE NOTE

DOCUMENTARY EVIDENCE IS REQUIRED FOR CHANGES IN THE DECEDENT'S (1) NAME, (2) RESIDENCE, (3) MARITAL STATUS, (4) DATE OF BIRTH AND AGE, (5) SOCIAL SECURITY NUMBER OR ADDITION OF AN "ALSO KNOWN AS" NAME.

SEE EXAMPLES ON BACK

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25417

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy Elizabeth Singley

2. Date of Death

Month Day Year
August 6 1997

3. Time of Death

5:55PM

4a. Facility Name (If not institution, give street and number)

Colonial Manor Homes

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

203-20-4420

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Aug 14 1908

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3023 Arundel On The Bay

10f. Zip Code

21403

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Nurse

16b. Kind of Business/Industry

Medical Industry

17. Father's Name (First, Middle, Last)

Raymond W. Toy

18. Mother's Name (First, Middle, Maiden Summa)

Margaret Emschewiler

19a. Informant's Name/Relationship (Type, Print)

Peggy L. Shoener (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

110 Oak Lane Sewickley, Pennsylvania 15143

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Montoursville Cemetery 8/12/97

Data

20c. Location - City or Town, State

Montoursville, PA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

John M. Taylor Funeral Home, Inc.
147 Duke of Gloucester St. Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Alzheimer's Dementia

Approximate Interval Between Onset and Death

5 yrs

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Acute renal failure / Oxygenation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

019838

29d. Date signed (Month, Day, Year)

8/7/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stuart E. Selouch 900 Bestgate Rd. Annapolis, Md. 21401

State
Registrar

31. Date filed (Month, Day, Year)

AUG 08 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 68760,

1. The first part of the report
describes the general situation
of the country and the
state of the economy.

2. The second part of the report
describes the results of the
survey and the conclusions
drawn from it.

3. The third part of the report
describes the measures taken
to improve the situation
and the results achieved.

4. The fourth part of the report
describes the future prospects
of the country and the
conclusions drawn from it.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25418

Amend# 20b, 20c cms 8/11/97 AACO Hlt Certificate of Death

Reg. No.

| | | | | | | |
|--|--|--|---|--------------------------------|---|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) TERESA | | 2. Date of Death Aug 07 97 | | 3. Time of Death 0025 | |
| | 4e. Facility Name (If not institution, give street and number) ANNAPOLI ANNE ARUNDEL MEDICAL CENTER | | 4b. City, Town, or Location of Death ANNAPOLIS | | 4c. County of Death ANNE ARUNDEL | |
| Funeral Director | 5. Social Security Number 220-30-2036 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 61 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) JULY 7 1936 |
| | 9. Birthplace (State or Foreign Country) MARYLAND | | | | | |
| To Be Completed by Funeral Director | 10e. State MARYLAND | | 10b. County ANNAPOLIS | | 10c. City, Town or Location ANNAPOLIS | |
| | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| | 10e. Street and Number 12 MONUMENT STREET | | 10f. Zip Code 21401 | | 10g. Citizen of What Country? US | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SELF EMPLOYED | | 16b. Kind of Business/Industry CHILD CARE | |
| | 17. Father's Name (First, Middle, Last) CLARENCE HAWKINS | | 18. Mother's Name (First, Middle, Maiden Surname) ELSIE EVANS | | | |
| | 19a. Informant's Name/Relationship (Type, Print) THERESA SAVOY (DAUGHTER) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 224 CROLL DRIVE ANNAPOLIS, MD. 21401 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) HILL CREST CEMETERY Maryland Veteran | | 20c. Location - City or Town, State Crownsville ANNAPOLIS, MD. | |
| | 21. Signature of Funeral Service Licensee Harry M. Reese | | 22. Name and Address of Facility WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401 | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Respiratory failure MOR BID OBESITY | | | | | Approximate Interval Between Onset and Death 2wks year |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | | | | |
| | 28a. Date of injury (Month, Day Year) M | | | | | 28b. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 28c. Describe how injury occurred | | | | | |
| | 28d. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| | 29b. Signature and title of certifier Michael J. Lafont | | 29c. License number 0 21438 | | 29d. Date signed (Month, Day, Year) August 07 97 | |
| | 30. Name and address of person who completed Cause of death (Item 23e) (Type, Print) MICHAEL J. LAFONT 600 RIDGEWAY WEST IN ANNAPOLIS MD 21401 | | | | | |
| | 31. Date filed (Month, Day, Year) AUG 11 1997 | | 32. Registrar's Signature John Davidson-Rodale | | | |
| | State Registrar | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25419

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|--|---|--------------------------|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Mary Staton | | | | | | 2. Date of Death Month Day Year July 31, 1997 | | 3. Time of Death 11:40 pm | |
| | 4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center | | | | | | 4b. City, Town, or Location of Death Annapolis | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 578-42-7720 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 83 Yrs. | | 8. Date of Birth (Month, Day, Year) Dec. 25, 1913 | | 9. Birthplace (State or Foreign Country) Washington, DC | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Prince George's | | 10c. City, Town or Location Bladensburg | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 10e. Street and Number 5999 Emerson Street #206 | | | | 10f. Zip Code 20710 | | 10g. Citizen of What Country? U.S.A. | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 Collage (1-4or 5+) 8 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | 16b. Kind of Business/Industry Own Home | | |
| | 17. Father's Name (First, Middle, Last) John Day | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Jamelia (Unknown) | | | |
| | 19a. Informant's Name/Relationship (Type, Print) John Staton - Son | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3929 Cove Road, Edgewater, Maryland 21037 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery | | Data 08/04/97 | | 20c. Location - City or Town, State Suitland, Maryland | | | |
| | 21. Signature of Funeral Service Licensee Claudette J. Bosch | | | | | | 22. Name and Address of Facility Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, Md. 20781 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediata Cause (Final disease or condition resulting in death) a. Suspected massive GI bleed Due to (or as a consequence of): b. with cardiopulmonary arrest Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 30 min. | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hip fracture, ORIF 7/30 | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier | | | | | | 29c. License number D37071 | | 29d. Date signed (Month, Day, Year) 8/1/97 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Ove 108 Forbes Street, Annapolis, Maryland 21401 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 04 1997 | | | | | | | | | | |
| 32. Registrar's Signature John Arundel | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

7

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25420

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ANN STINEY | | | | 2. Date of Death Month JULY Day 30 Year 1997 | | 3. Time of Death 0900 | | |
| | 4a. Facility Name (If not Institution, give street and number) Holy Cross Hospital | | | | 4b. City, Town, or Location of Death Silver Spring | | 4c. County of Death Montgomery | | |
| Funeral Director | 5. Social Security Number 579-52-6525 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 60 Yrs. | | 8. Date of Birth (Month, Day, Year) Dec. 4, 1936 | | |
| | 9. Birthplace (State or Foreign Country) South Carolina | | 10a. State Maryland | | 10b. County Prince Georges | | 10c. City, Town or Location Capitol Heights | | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 1300 Chapel Oaks Drive | | 10f. Zip Code 20743 | | 10g. Citizen of What Country? United States of America | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th | | College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) House Keeping Technician | | 16b. Kind of Business/Industry Federal Government | | | |
| 17. Father's Name (First, Middle, Last) Jacob Pendergrass | | | | 18. Mother's Name (First, Middle, Maiden Surname) Ollie Mae Summers | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Willie Stiney (Spouse) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1300 Chapel Oaks Dr., Capitol Heights, Md 20743 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Park | | 20c. Date 08/02/97 | | 20d. Location - City or Town, State Landover, Maryland | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Lawrence W. Plunkett, Inc. 2504 - 28th St., NE., Wash., D. C. 20018-1413 | | | | | |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. INTRA CEREBRAL HEMORRHAGE Due to (or as a consequence of): HYPERTENSION Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last DIABETES MELLITUS Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of injury (Month, Day, Year) | | 28b. Time of injury M | |
| | | 28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier | | 29c. License number D50300 | | 29d. Date signed (Month, Day, Year) July 30, 1997 | | | |
| 30. Name and address of person who completed cause of death (item 23e) (Type, Print) THOMAS J ANTHONY, MD 11119 ROCKVILLE PIKE, #316, ROCKVILLE MD 20852 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 04 1997 | | 32. Registrar's Signature | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "Natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25421

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CLARENCE C. SCOTT

2. Date of Death

Month

Day

Year

August

4

1997

3. Time of Death

4:30 pm

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

5. Social Security Number

234-40-9247

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

May 1, 1927

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

D. C.

10b. County

N/A

10c. City, Town or Location

Washington

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

2535 Bladensburg Road, Northeast

10f. Zip Code

20018

10g. Citizen of What Country?

United States of America

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sear's Technician

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Clarence C. Scott, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Johnson

19a. Informant's Name/Relationship (Type, Print)

Movita E. Scott, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2535 Bladensburg Rd., NE., Washington, D.C. 20018

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Riverdale Crematory

Date

8/6/97

20c. Location - City or Town, State

Riverdale, Maryland

21. Signature of Funeral Service Licensee

#810

22. Name and Address of Facility

Lawrence W. Plunkett, Inc. Funeral Home

2504 - 28th St., NE., Wash., D. C. 20018-1413

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE, WITH

Due to (or as a consequence of):

SVC & Hypoxemia

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. CORONARY ARTERY DISEASE, AND

Due to (or as a consequence of):

HYPERTENSION

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

① MULTIPLE PREVIOUS STROKES WITH
HEMIPLEGIA ② DIABETES MELLITUS
③ HYPERAMYLASEMIA ④ CACHEXIA
⑤ STATUS GASTRIC TUBE FEEDING

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Mohammed A. Mannan MD

29c. License number

D24593

29d. Date signed (Month, Day, Year)

8.4.97

30. Name and address of person who completed cause of death (item 23e) (Type, Print)

Mohammed A. Mannan, M. D., 3331 Toledo Terr., Suite #206, Hyattsville, Md 20782

31. Date filed (Month, Day, Year)

AUG 08 1997

32. Registrar's Signature

John A. Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

97 25422

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | |
|---|--|--|---|--|---|--------------------------------|--------------------------------|---|--|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Eva Bernice Tomlinson | | | | 2. DATE OF DEATH MONTH DAY YEAR August 4, 1997 | | | | 3. TIME OF DEATH 4:17 P M | | | | |
| 4. SOCIAL SECURITY NUMBER 413-38-6265 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 69 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year) April 25, 1928 | | 8. BIRTHPLACE (State or Foreign Country) Tennessee | |
| 9a. FACILITY NAME (If not institution, give street and number) Saint Joseph Medical Center | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson | | | | 9c. COUNTY OF DEATH Baltimore | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Cecil | | 10c. CITY, TOWN OR LOCATION Port Deposit | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | |
| 10e. STREET AND NUMBER 47 West Peppermint Drive | | | | | 10f. ZIP CODE 21904 | | | 10g. CITIZEN OF WHAT COUNTRY? United States | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 4 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Nursing Assistant | | | | 16b. KIND OF BUSINESS/INDUSTRY Health Care | | | | |
| 17. FATHER'S NAME (First, Middle, Last) James Flanigan | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mae Johnson | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) William Tomlinson/husband | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 47 West Peppermint Drive, Port Deposit, MD 21904 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Rosebank Cemetery | | | DATE 8/8/97 | | 20c. LOCATION — City or Town, State Calvert, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald S. Hicks</i> | | | | | 22. NAME AND ADDRESS OF FACILITY Hicks Home for Funerals, P.A. 103 West Stockton St., Elkton, MD 21921 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | | | | Approximate Interval Between Onset and Death | | |
| a. <u>ARRHYTHMIA</u> DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | 5 MIN | | |
| b. <u>HEART FAILURE</u> DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | 1 HOUR | | |
| c. <u>VALVULAR HEART DISEASE</u> DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | 1 MONTH | | |
| d. <u>ATHEROSCLEROTIC CORONARY ARTERY DISEASE</u> | | | | | | | | | | 10 YEARS | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Charles F. O'Donnell</i> | | | | | | 29c. LICENSE NUMBER D-09383 | | 29d. DATE SIGNED (Month, Day, Year) August 4, 1997 | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Charles F. O'Donnell, M.D., 111 Hamlet Hill Road, Baltimore, Maryland 21210 | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) AUG 07 1997 | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson</i> | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Levitt in a pair

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25423

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JAMES WILLIS THOMPSON Jr. | | | | 2. Date of Death Month Day Year AUGUST 6, 1997 | | 3. Time of Death 11:45 p.m. | |
| | 4a. Facility Name (If not institution, give street and number) 421 BROAD STREET | | | | 4b. City, Town, or Location of Death PERRYVILLE | | 4c. County of Death CECIL | |
| Funeral Director | 5. Social Security Number 218-16-0841 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 72 Yrs. | | 8. Date of Birth (Month, Day, Year) DEC. 4, 1924 | |
| | 9. Birthplace (State or Foreign Country) MARYLAND | | 10a. State MARYLAND | | 10b. County CECIL | | 10c. City, Town or Location PERRYVILLE | |
| To Be Completed by Funeral Director | Usual Residence of Decedent 10a. State MARYLAND | | | | 10b. County CECIL | | 10c. City, Town or Location PERRYVILLE | |
| | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 10e. Street and Number 421 BROAD STREET | | 10f. Zip Code 21903 | |
| | 10g. Citizen of What Country? USA | | | | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1943-46 | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collega (1-4or 5+) | |
| | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Guided Missile | | | | 16b. Kind of Business/Industry Federal Govt. | | 17. Father's Name (First, Middle, Last) JAMES W. THOMPSON SR. | |
| | 18. Mother's Name (First, Middle, Maiden Surname) ALICE MALINDA BIRD | | | | 19a. Informant's Name/Relationship (Type, Print) M. JOAN THOMPSON WIFE | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 421 BROAD ST. PERRYVILLE, MARYLAND 21903 | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St. MARKS CHURCH CEMETERY | | 20c. Location - City or Town, State 8/10/97 PERRYVILLE, MARYLAND | |
| | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home Perryville, Maryland 21903 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e. Cancer of lung(Rt) c Metastasis Due to (or as a consequence of): b. Brain Mass (Cancer), Metastasis Due to (or as a consequence of): c. Due to (or as a consequence of): d. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebrovascular Accident Diabetes Mellitus | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier <i>[Signature]</i> | | 29c. License number D4315 | | |
| 29d. Date signed (Month, Day, Year) 8-7-97 | | | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Mirza A. Baig, M.D. 615 South Union Ave., Havre de Grace, Md. 21078 | | | | |
| 31. Date filed (Month, Day, Year) AUG 08 1997 | | | | 32. Registrar's Signature <i>[Signature]</i> | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25424

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Emma Mae Turner

2. Date of Death

Month Day Year
July 24, 1997

3. Time of Death

1:10pm

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

579-30-7143

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 25, 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Wheaton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

11108 Luttrell Lane

10f. Zip Code

20902

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12th

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Nurse Assistant

16b. Kind of Business/Industry

Medical

17. Father's Name (First, Middle, Last)

John W. Marr

18. Mother's Name (First, Middle, Maiden Surname)

Mary E. Barnes

19a. Informant's Name/Relationship (Type, Print)

Bernard D. Turner, Sr (Husband) 11108 Luttrell Lane, Wheaton, MD 20902

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Gate of Heaven Cem. 7/30/97 Silver Spring, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SNOWDEN FUNERAL HOME, P.A.
ROCKVILLE, MD 2085023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Pancreatic Abscess

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

3 hrs

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Pancreatitis

Due to (or as a consequence of):

4 hrs

c. Pancreatic Cancer (Neuroendocrine)

Due to (or as a consequence of):

months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Metastatic Cancer to liver and Brain

Chronic Obstructive Lung Disease

Gastrointestinal Bleeding

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D21931

29d. Date signed (Month, Day, Year)

7-25-97

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Steven A. Burger MD 2101 Medical pk Dr Silver Spring, Md. 20902

31. Date filed (Month, Day, Year)

JUL 28 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25425

Certificate of Death

Reg. No.

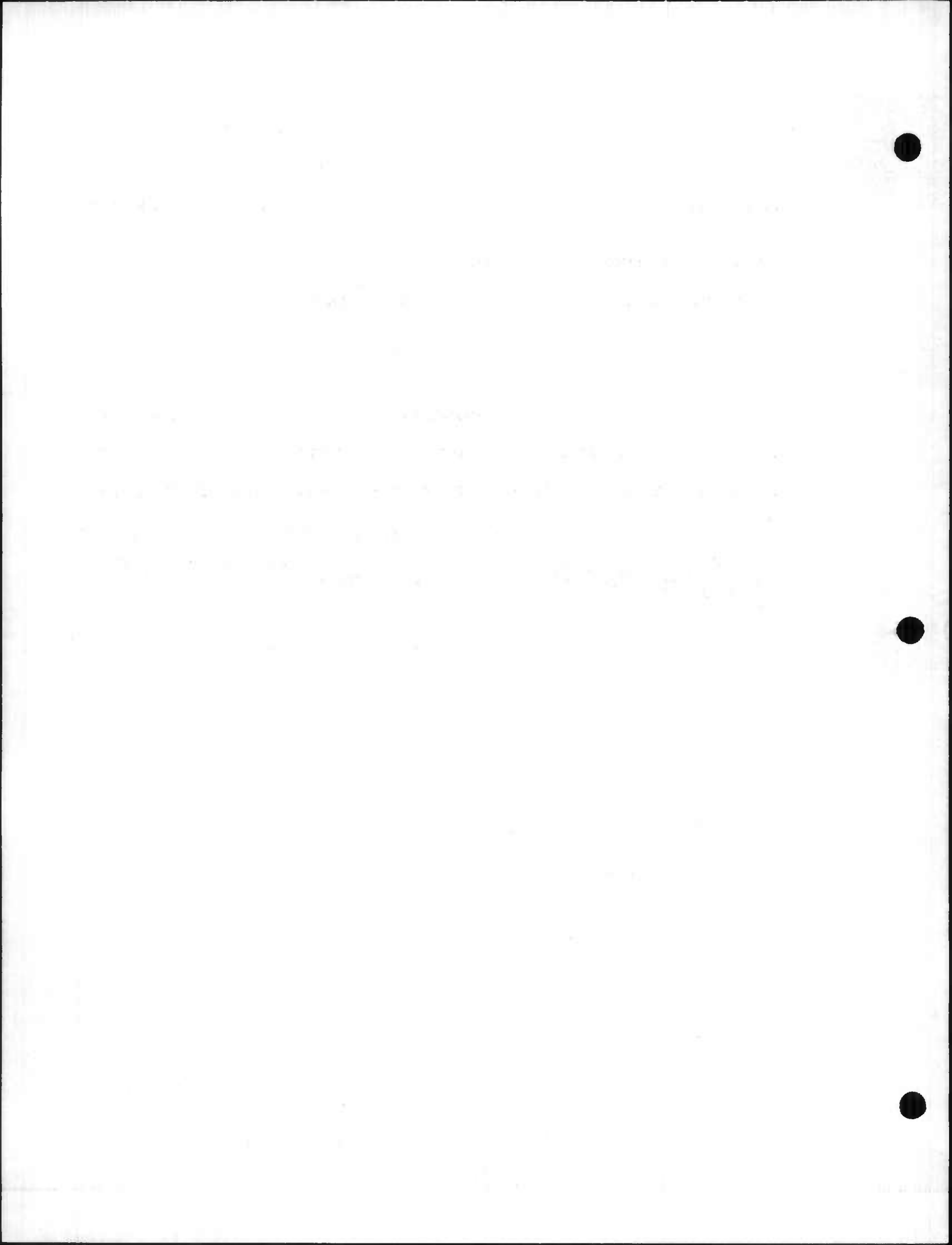
| | | | | | | | | |
|--|---|--|---|--|--|--------------------------------|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>E. Louise Thomas</i> | | | | 2. Date of Death Month <i>August</i> Day <i>3</i> Year <i>1997</i> | | 3. Time of Death <i>12:45</i> | |
| | 4a. Facility Name (If not institution, give street and number) <i>Bayview Medical Center</i> | | | | 4b. City, Town, or Location of Death <i>Baltimore</i> | | 4c. County of Death <i>N/A</i> | |
| Funeral Director | 5. Social Security Number <i>212-20-8287</i> | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) <i>85</i> Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) <i>AUG. 4. 1911</i> | 9. Birthplace (State or Foreign Country) <i>MARYLAND</i> |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State <i>MARYLAND</i> | | 10b. County <i>ANNE ARUNDEL</i> | | 10c. City, Town or Location <i>FERNDAL</i> | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number <i>106 EUGENIA AVENUE</i> | | | | 10f. Zip Code <i>21061</i> | | 10g. Citizen of What Country? <i>U.S.A.</i> | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <i>WHITE</i> | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>N/A</i> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>HOMEMAKER</i> | | 16b. Kind of Business/Industry <i>OWN HOME</i> | | | |
| | 17. Father's Name (First, Middle, Last) <i>EUGENE WILLARD SHIVES</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <i>EDITH JACOB</i> | | | |
| | 19a. Informant's Name/Relationship (Type, Print) <i>EDWIN HAROLD THOMAS, JR. (SON)</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3718 GREENVALE ROAD, BALTIMORE, MD. 21229</i> | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>GLEN HAVEN MEMORIAL PARK</i> | | Data <i>8/7/97</i> | | 20c. Location - City or Town, State <i>GLEN BURNIE, MD.</i> | |
| | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility <i>SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061</i> | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line. <i>Small Bowel Obstruction</i> | | | | | | | |
| | Approximate Interval Between Onset and Death <i>24 hours</i> | | | | | | | |
| Physician /Medical Examiner | Immediata Cause (Final disease or condition resulting in death) <i>Small Bowel Obstruction</i> Due to (or as a consequence of): | | | | | | | |
| | Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>Small Cell Lung Cancer</i> <i>tobacco use</i> | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Small Cell Lung Cancer</i> <i>tobacco use</i> | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury <i>M</i> | | 28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier <i>[Signature]</i> | | | | 29c. License number <i>96706</i> | | 29d. Date signed (Month, Day, Year) <i>8/3/97</i> | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Bayview Medical Center Baltimore, MD</i> | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) <i>AUG 05 1997</i> | | 32. Registrar's Signature <i>[Signature]</i> | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25426

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Henry D. Tubbs

2. Date of Death
Month Day Year

Aug. 4, 1997

3. Time of Death

2:05 A.M.

4e. Facility Name (If not institution, give street and number)

1614 Forest Park Drive

4b. City, Town, or Location of Death

Forestville

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

420-42-6399

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

62 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

11/21/34

9. Birthplace (State or Foreign Country)

Alabama

Usual Residence of Decedent

10a. State

Md.

10b. County

P.G.

10c. City, Town or Location

Forestville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1614 Forest Park Drive

10f. Zip Code

20747

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates:

50-'64

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

US..Post Office

17. Father's Name (First, Middle, Last)

Alex Tubbs

18. Mother's Name (First, Middle, Maiden Surname)

Lucy Kennedy

19a. Informant's Name/Relationship (Type, Print)

Marjorie J. Tubbs/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as # 10 above

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Mem. Park 8/8/97

Date

20c. Location - City or Town, State

Landover, Md.

21. Signature of Funeral Service Licensee

Darryl H. Cratt

22. Name and Address of Facility

H.S. Washington & Sons, Inc.
4925 Burroughs Ave., N.E.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CHOLANGIO CARCINOMA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

one year.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dennis A. Cullen

29c. License number

MD 40216.

29d. Date signed (Month, Day, Year)

8/15/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis A. Cullen, M.D. 4333 Old Branch Ave., Marlow Hgts., Md. 20748

31. Date filed (Month, Day, Year)

AUG 07 1997

32. Registrar's Signature

John A. Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25427

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CLARA S. TALLEY

2. Date of Death

July 23, 1997

3. Time of Death

3:58 AM

4a. Facility Name (If not institution, give street and number)

Prince Georges Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

PRINCE GEORGES

Funeral
Director

5. Social Security Number

438-16-3819

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 4, 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

N/A

10b. County

N/A

10c. City, Town or Location

Washington, DC

10d. Inside City Limits

Yes ☒ No ☐

10e. Street and Number

3001 Bladensburg Rd. NE, #919

10f. Zip Code

20018

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Addie L. Quonn

19a. Informant's Name/Relationship (Type, Print)

Robert Talley (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3621 28th St., NE, Washington, DC 20018

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Mark Church Cem.

Date

7/28/97

20c. Location - City or Town, State

Boysds, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SNOWDEN FUNERAL HOME, P.A.
ROCKVILLE, MD 20850

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Acute Ischemic Brain

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 day

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

severe, ventilator dependent
chronic obstructive lung disease, hyperkalemia
respiratory failure, resolved pneumonia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ NoHospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

N/A

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

201852

29d. Date signed (Month, Day, Year)

JULY 23 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul A. DeVore MD 4203 Queensbury Rd Hyattsville MD 20787

31. Date filed (Month, Day, Year)

JUL 28 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

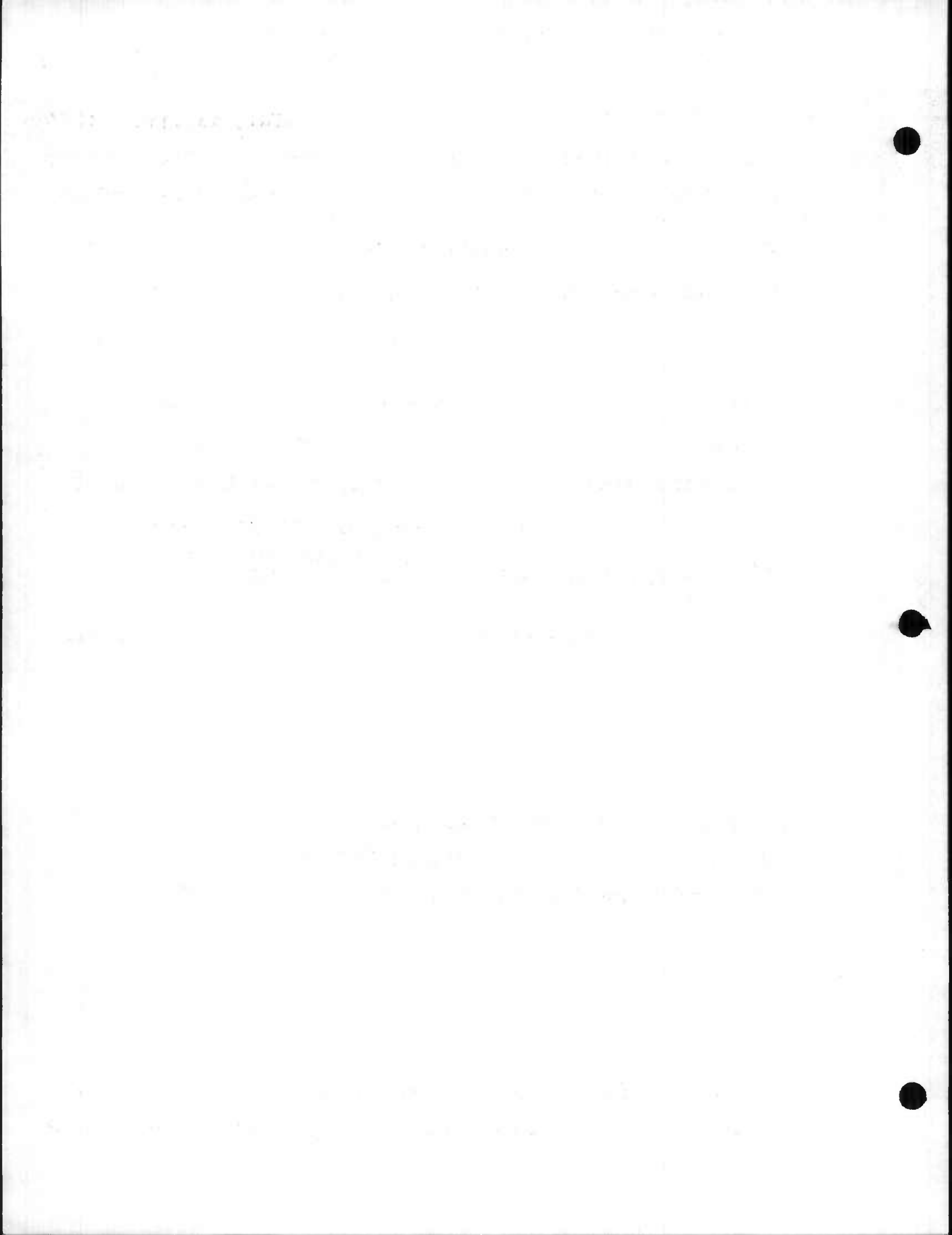
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25428

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|---|---|---|--|---|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) James Franklin Vance | | | | 2. Date of Death Month AUGUST Day 6 Year 1997 | | 3. Time of Death 3:45 AM | |
| | 4a. Facility Name (If not institution, give street and number) PHYSICIANS MEMORIAL HOSPITAL | | | | 4b. City, Town, or Location of Death LAPLATA | | 4c. County of Death CHARLES | |
| Funeral Director | 5. Social Security Number 215-38-3654 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 79 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 12-31-1917 | | 9. Birthplace (State or Foreign Country) Arkansas |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | 10b. County Prince George's | 10c. City, Town or Location Oxon Hill | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number 300 Careybrook Lane | | | 10f. Zip Code 20745 | | 10g. Citizen of What Country? U.S.A | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ yrs | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Lawyer | | 16b. Kind of Business/Industry Law Self Employed | | | |
| | 17. Father's Name (First, Middle, Last) Thadeus B. Vance | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mabel Claire Blair | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Elizabeth E. Vance wife | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 Careybrook Lane, Oxon Hill Maryland 20745 | | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory | | 20c. Date 08-07-1997 | | 20d. Location - City or Town, State Alexandria, Va | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility George P. Kalas Funeral Home 6160 Oxon Hill Rd Oxon Hill MD | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. RESPIRATORY FAILURE Due to (or as a consequence of): BILATERAL PNEUMONIA Due to (or as a consequence of): SEPSIS Due to (or as a consequence of): MALNUTRITION | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| Physician /Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) August 06 1997 | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| State Registrar | 29b. Signature and title of certifier Attending | | | | 29c. License number D-44436 | | 29d. Date signed (Month, Day, Year) August 06 1997 | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) ASHVINKUMAR PATEL M.D. 603 POST OFFICE ROAD SUITE 207 WALDORF MD. 20602 | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 07 1997 | | | | 32. Registrar's Signature | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

CLARK 2 (MAY 6)

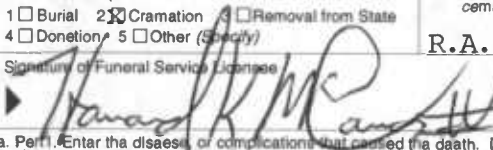
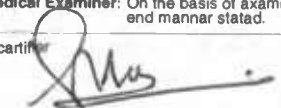
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25429

| | | | | | | | | | | |
|-------------------------------------|---|--|---|--|--|--|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JAMES RICHARD WORKENAOUR | | | | | | 2. Date of Death Month Day Year August 04 1997 | | 3. Time of Death 8:55 PM | |
| | 4a. Facility Name (If not institution, give street and number) VA Maryland Health Care system | | | | | | 4b. City, Town, or Location of Death Perry Point | | 4c. County of Death Cecil | |
| Funeral Director | 5. Social Security Number 232-52-1125 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 63 Yrs. | | 8. Date of Birth (Month, Day, Year) April 30, 1934 | | 9. Birthplace (State or Foreign Country) West Virginia | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State N. Carolina | | 10b. County Pasquotank | | 10c. City, Town or Location Elizabeth City | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number 1131 West Church Street | | | | 10f. Zip Code 27909 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 Collegia (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Drywall Installer | | | 16b. Kind of Business/Industry Construction | | |
| | 17. Father's Name (First, Middle, Last) William Russell Workenaour | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Martha Sophia Welty | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Ralph G. Workenaour - Brother | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 911 Davies Ave., Akron, Ohio 44306 | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) R.A. Ferris & Company | | Data 8-8-97 | | 20c. Location - City or Town, State W. Chester, PA | | | |
| | 21. Signature of Funeral Service Licensee  | | | | | | 22. Name and Address of Facility Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Severe Congestive Heart Failure Dua to (or as a consequence of): b. Ischemic Heart Disease Dua to (or as a consequence of): c. Dua to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | |
| | Approximate Interval Between Onset and Death Weeks Years | | | | | | | | | |
| Physician /Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| | 29b. Signature and title of certifier  | | | | | | 29c. License number D20215 | | 29d. Date signed (Month, Day, Year) 8/4/97 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KARMACHANDRA NAIR, M.D., VA Maryland Health Care System, Perry Point, MD | | | | | | | | | |
| | 31. Date filed (Month, Day, Year) AUG 7 1997 | | 32. Registrar's Signature  | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Name Patient Known to Physician: WORKENAOUR, James Richard

Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 25430

Reg. No.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|----------------------------------|---|--|--|----------------------------------|--|--|---|-----------------------------------|--|--|--|--|--|---|----------------------------------|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|----------------------------------|--|--|--|--|--|----|--|--|--|--|--|----------------------------------|--|----|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) RUSSELL C. Wright | | | | 2. Date of Death Month Day Year August 10, 1997 | | 3. Time of Death 9:40P | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE CITY | | 4c. County of Death | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 222-30-9968 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 48 Yrs. | | 8. Date of Birth (Month, Day, Year) May 23, 1949 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Usual Residence of Decedent | | 9. Birthplace (State or Foreign Country) Delaware | | 10. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Delaware | | 10b. County Kent | | 10c. City, Town or Location Smyrna | | 10d. Inside City Limits | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 10e. Street and Number 434 Paul Drive | | 10f. Zip Code 19977 | | 10g. Citizen of What Country? United States | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1967-70 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No, if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Deliveryman | | 16b. Kind of Business/Industry Propane | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last) Medford Wright | | | | 18. Mother's Name (First, Middle, Maiden Surname) Margaret Cannone | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Linda L. Wright/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 434 Paul Drive, Smyrna, Delaware 19977 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Odd Fellows Cemetery | | 20c. Location - City or Town, State Smyrna, Delaware | | 20d. Date August 14, 1997 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee Donald S. Hicks | | | | 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 West Stockton St., Elkton, MD 21921 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td colspan="6">a. End Stage Liver Disease</td> <td rowspan="4">Approximate Interval Between Onset and Death 2 months</td> </tr> <tr> <td colspan="6">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td colspan="6">b. Hepatitis C virus</td> </tr> <tr> <td colspan="6">Due to (or as a consequence of):</td> </tr> <tr> <td colspan="6">c.</td> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td colspan="6">d.</td> <td colspan="2"></td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. End Stage Liver Disease | | | | | | Approximate Interval Between Onset and Death 2 months | Due to (or as a consequence of): | | | | | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Hepatitis C virus | | | | | | Due to (or as a consequence of): | | | | | | c. | | | | | | Due to (or as a consequence of): | | d. | | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | a. End Stage Liver Disease | | | | | | Approximate Interval Between Onset and Death 2 months | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Hepatitis C virus | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c. | | | | | | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Physician /Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alcohol Abuse | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Janine Romanello M.D. | | 29c. License number RES-000 | | 29d. Date signed (Month, Day, Year) August 10, 1997 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Janine Romanello 110 Tower, Johns Hopkins Hospital, Baltimore MD 21205 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 31. Date filed (Month, Day, Year) AUG 12 1997 | | 32. Registrar's Signature Davidson-Randell | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

4 HVA

note: see ref

gm
5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25431

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Eleanor Jacobson Williams

2. Date of Death

Month Day Year
July 25, 1997

3. Time of Death

1:30 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

16209 Orchard View Court

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

5. Social Security Number

509-48-6596

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
September 1, 1914

9. Birthplace (State or Foreign Country)

Minnesota

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

16209 Orchard View Court

10f. Zip Code

20878

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Nurse

16b. Kind of Business/Industry

Medical

17. Father's Name (First, Middle, Last)

Eric Jacobson

18. Mother's Name (First, Middle, Maiden Summa)

Mina Sjolin

19a. Informant's Name/Relationship (Type, Print)

Nancy Krause Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16209 Orchard View Court, Gaithersburg, Maryland 20878

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Chesapeake Crematory

Data

7-26-97

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Rapp Funeral Services, P.A.

933 Gist Avenue, Silver Spring, Maryland 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Failure to Thrive

Due to (or as a consequence of):

b. Compression Fractures with Intractable Pain

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Severe End-stage Rheumatoid Arthritis

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

26. Place of Death (Check only one)

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending
Investigation☐ Could not be
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury28c. Injury at
Work?☐ Yes ☒ No28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

233129

29d. Date signed (Month, Day, Year)

7/25/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Melinda Wolf, M.D. 14820 Physician's Lane, Ste. 241, Rockville, MD 20850

31. Date filed (Month, Day, Year)

JUL 28 1997

32. Registrar's Signature

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

97-4162-031

B. K. S

GERALDINE B. WHITE

Items: 23a part I, 28d per MEO G-752 10/20/97 dh

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25432

| | | | | | | | | |
|--|---|---|---|---|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) GERALDINE EMMA WHITE | | | | 2. Date of Death Month Day Year JULY 26, 1997 | | 3. Time of Death 1:20 PM | |
| | 4a. Facility Name (If not institution, give street and number) ROUTE#107 OFF ROUTE#28 WEST | | | | 4b. City, Town, or Location of Death POOLESVILLE | | 4c. County of Death MONTGOMERY | |
| Funeral Director | 5. Social Security Number 578-34-7494 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 82 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) JULY 27, 1914 | |
| | 9. Birthplace (State or Foreign Country) OTTAWA, CANADA | | | | | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | 10a. State D.C. | | 10b. County N/A | | 10c. City, Town or Location WASHINGTON, D.C. | | | |
| | 10e. Street and Number 5111 41ST STREET, N.W. | | | | 10f. Zip Code 20016 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) +2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CLERICAL SECRETARY, ASSISTANT | | 16b. Kind of Business/Industry JOSEPH GAWLER'S SONS INC. | | | |
| | 17. Father's Name (First, Middle, Last) PAUL GRONSKI | | | | 18. Mother's Name (First, Middle, Maiden Surname) APPOLONIA REMBISZ | | | |
| | 19a. Informant's Name/Relationship (Type, Print) EDWARD R. BLOOM SON | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 SOUTH CHERRY GROVE, ANNAPOLIS, MD 21401 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) GATE OF HEAVEN CEMETERY | | Date 7/31/97 | | 20c. Location - City or Town, State SILVER SPRING, MD | |
| | 21. Signature of Funeral Service Licenses <i>Joseph P. Peters</i> | | | | 22. Name and Address of Facility JOSEPH GAWLER'S SONS, INC., 5130 WI AVENUE, N.W. WASHINGTON, D.C. 20016 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last MULTIPLE INJURIES a. <i>Rupture aortic aneurysm complicated by multiple injuries</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) ROADWAY | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) 7-26-97 | | 28b. Time of Injury 1300 M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) street | | | | 28d. Describe how injury occurred <i>Driver was incapacitated, struck by driver of auto struck utility pole</i> 28f. Location (Street and Number or Rural Route Number, City or Town, State) <i>Route 107, 18501 White Ferry Road Montgomery County</i> | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation. In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier <i>Donald G. Wright MD</i> | | | | 29c. License number O.C.M.E | | 29d. Date signed (Month, Day, Year) JULY 27, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DONALD G. WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) JUL 30 1997 | | | | 32. Registrar's Signature <i>John Anderson-Randall</i> | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

12

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Handwritten mark or signature at the top center of the page.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25433

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jack

Wiener

2. Date of Death

Month Day Year
July 27, 1997

3. Time of Death

7:28am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

5705 Kingswood Road

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

493-24-7186

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec 6, 1916

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5705 Kingswood Road

10f. Zip Code

20814

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Research Analyst

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Morris Wiener

18. Mother's Name (First, Middle, Maiden Surname)

Rae Borstein

19a. Informant's Name/Relationship (Type, Print)

Florence Wiener-spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5705 Kingswood Rd Bethesda MD 20814

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Mt. Comfort Crematory

Date

7/29/97 Alexandria, VA

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

-Daniel
Simons

22. Name and Address of Facility

Edward Sagel Funeral Direction

1091 Rockville Pike Rockville, MD 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. TERMINAL RENAL FAILURE

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

2 months

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. ARTERIO SCLEROSIS

Due to (or as a consequence of):

years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Heart Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D3319

29d. Date signed (Month, Day, Year)

July 28, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Loreto Albiol, M.D. 2 Wisconsin Circle Chevy Chase, MD 20815

State
Registrar

31. Date filed (Month, Day, Year)

JUL 29 1997

32. Registrar's Signature

Julia Davidson-Randall

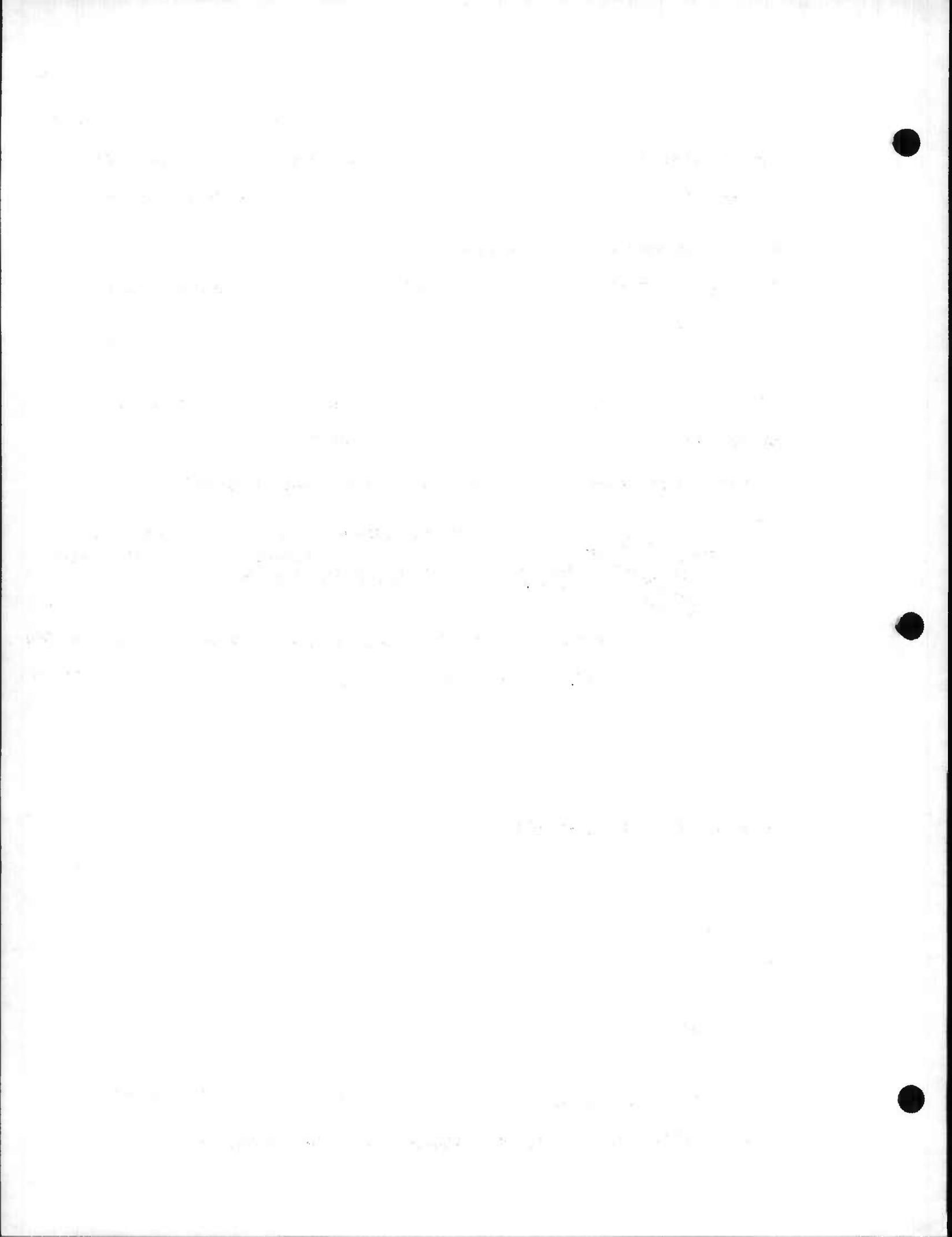
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25434
Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Frances Virginia Wallrodt

2. Date of Death
Month Day Year
July 26, 1997
3. Time of Death
8:55 PM

4a. Facility Name (If not institution, give street and number)

18 Brookes Avenue

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

5. Social Security Number

219-64-3756

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 6, 1912

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

18 Brookes Avenue

10f. Zip Code

20877

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

James Samuel Henkel

18. Mother's Name (First, Middle, Maiden Surname)

Nanny Weeks

19a. Informant's Name/Relationship (Type, Print)

George Wallrodt

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20 Brookes Avenue Gaithersburg, Maryland 20877

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

7/30/97

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

Andrew J. Cole

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Pulmonary Fibrosis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation

Osteoporosis

reflux
Gastroesophageal stricture of Esophagus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Byrl D. Johnson M.D.

29c. License number

D-19042

29d. Date signed (Month, Day, Year)

July 29, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

BYRL D. JOHNSON M.D. 911 Russell Avenue Gaithersburg, Maryland 20879

31. Date filed (Month, Day, Year)

JUL 30 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

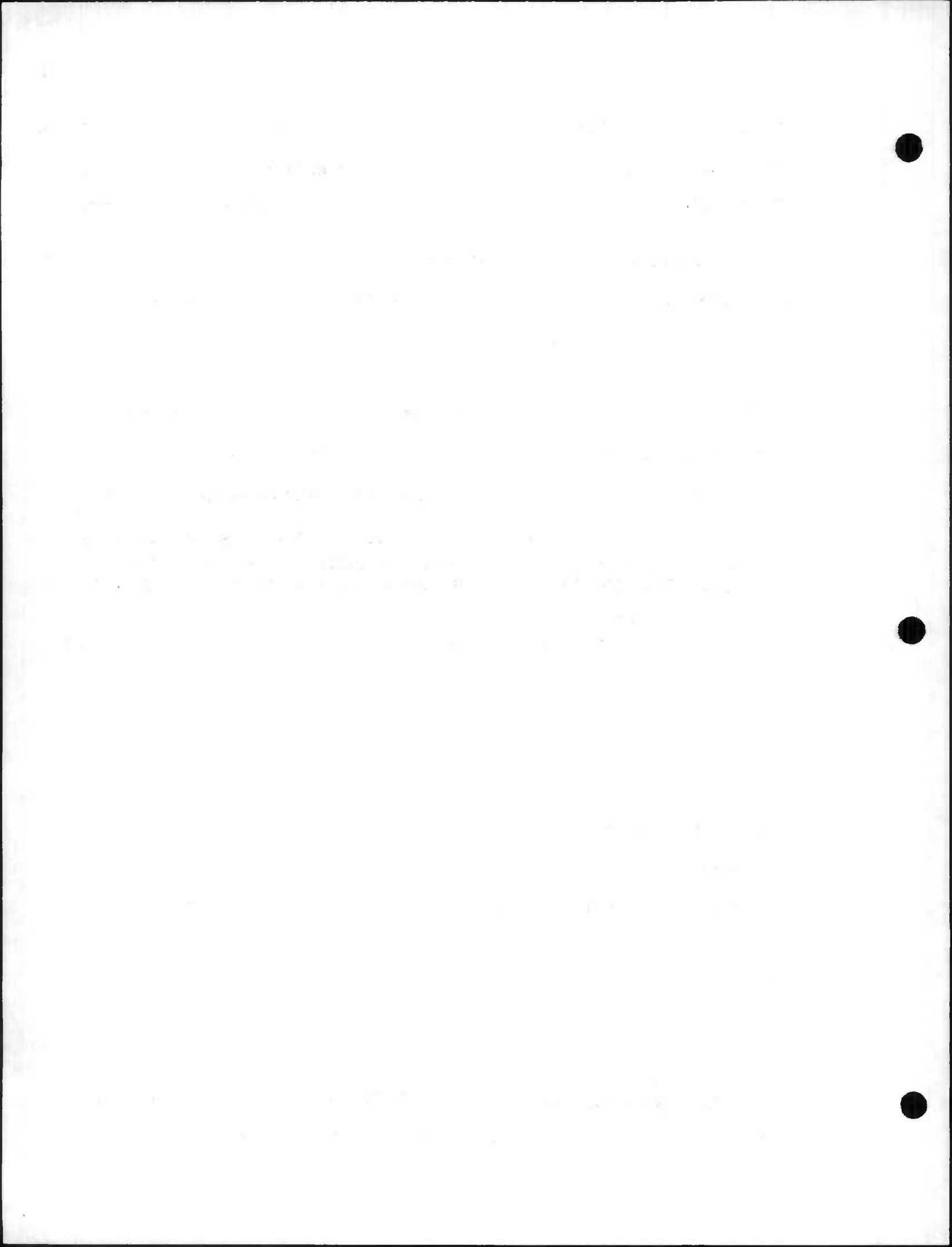
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25435

Items: 5, 18, 19a per FH G-751 9/10/97 dh
Amend #7, 8/1/97, BMW, Montg. Co. per F.H.

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Sophie Wolfson

2. Date of Death
Month Day Year
July 31, 19973. Time of Death
10:20AM

4a. Facility Name (If not Institution, give street and number)

Randolph Hills Nursing Home

4b. City, Town, or Location of Death

Wheaton

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

105-05-61825
074094065

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 31, 1908

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Md.

10b. County

Montgomery

10c. City, Town or Location

Wheaton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4011 Randolph Rd.

10f. Zip Code

20902

10g. Citizen of What Country?

US

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Isaac Levy

18. Mother's Name (First, Middle, Maiden Surname)

Anna Unknown Levy

19a. Informant's Name/Relationship (Type, Print)

D Leah Meltzer

Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13 W. Linden Ct. Alexandria, Va. 22301

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Beth El Cemetery 8/3/97

Date

20c. Location - City or Town, State

Syracuse, Ny.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Edward Sagel Funeral Direction
1091 Rockville Pike Rockville, Md. 20852

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Pneumonia

Approximate Interval Between Onset and Death

48 Hours

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?
1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier

29c. License number

D34032

29d. Date signed (Month, Day, Year)

July 31, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Jeanne P. Asher Md. 3720 Farragut Ave. Kensington, Md. 20895

31. Date filed (Month, Day, Year)

AUG 01 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25436

Amend # 18 8-5-97 cms AACO Health

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|--|--|---|--|---|----|---------------------------|--|----|---------------|------------|----|-----------------------------|------------|----|-------------------------------|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) EARL V WILKINSON JR | | | | 2. Date of Death Aug 1 1997 | | 3. Time of Death 11:45AM | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center | | | | 4b. City, Town, or Location of Death Annapolis | | 4c. County of Death Anne Arundel | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 435-26-4782 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 74 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) May 23, 1923 | 9. Birthplace (State or Foreign Country) Louisiana | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | 10b. County Anne Arundel | 10c. City, Town or Location Severna Park | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | |
| | 10e. Street and Number 280 Oak Court | | | 10f. Zip Code 21146 | | 10g. Citizen of What Country? USA | | | | | | | | | | | | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) U.S. Air Force | | 16b. Kind of Business/Industry U.S. Air Force | | | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last) Earl V. Wilkinson, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname) Maydea M. Nixon | | | | | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Margaret Wilkinson/wife | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 280 Oak Court, Severna park, MD 21146 | | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cem. | | Date Aug 7 1997 | | 20c. Location - City or Town, State Arlington, VA | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146 | | | | | | | | | | | | | | | | | |
| | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | |
| | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>Respiratory insuff</td> <td>Approximate interval Between Onset and Death 4wk</td> </tr> <tr> <td>b.</td> <td>Sepsis</td> <td>4wk</td> </tr> <tr> <td>c.</td> <td>aspiration pneumonia</td> <td>8wk</td> </tr> <tr> <td>d.</td> <td>C1C1 fracture Anterior</td> <td>8wk</td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. | Respiratory insuff | Approximate interval Between Onset and Death 4wk | b. | Sepsis | 4wk | c. | aspiration pneumonia | 8wk | d. | C1C1 fracture Anterior |
| Immediate Cause (Final disease or condition resulting in death) | a. | Respiratory insuff | Approximate interval Between Onset and Death 4wk | | | | | | | | | | | | | | | | | |
| | b. | Sepsis | 4wk | | | | | | | | | | | | | | | | | |
| | c. | aspiration pneumonia | 8wk | | | | | | | | | | | | | | | | | |
| | d. | C1C1 fracture Anterior | 8wk | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ↓ + th and COPD HASCID, ALZHEIMER Dementia Chronic | | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner | | 29b. Signature and title of certifier | | | | | | | | | | | | | | | | | | |
| 29c. License number 021438 | | 29d. Date signed (Month, Day, Year) Aug 1 97 | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) MICHAEL J LAVE 1200 KINGLY AVE STE 120 ANNAPOLIS MD 21401 | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 05 1997 | | 32. Registrar's Signature | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25437

Certificate of Death

Reg. No.

| | | | | | |
|-------------------------------------|---|--|---|--------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Claude E Whitmoyer | | 2. Date of Death Month July Day 30 Year 1997 | | 3. Time of Death 2:25am |
| | 4a. Facility Name (If not institution, give street and number) Johns Hopkins Bayview Medical Center | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death |
| Funeral Director | 5. Social Security Number 185-36-2518 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 50 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) 10-11-1946 | | 9. Birthplace (State or Foreign Country) PENNSYLVANIA | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | |
| | 10a. State MARYLAND | 10b. County ANNE ARUNDEL | 10c. City, Town or Location SEVERN | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10e. Street and Number 775 ELMHURST ROAD | | 10f. Zip Code 21144 | | 10g. Citizen of What Country? U.S.A. |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1966-1986 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1 | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) E-6 | | 16b. Kind of Business/Industry U. S. AIR FORCE | | |
| | 17. Father's Name (First, Middle, Last) JASON WHITMOYER | | 18. Mother's Name (First, Middle, Maiden Surname) RUTH MAUST | | |
| | 19a. Informant's Name/Relationship (Type, Print) JUDITH ELAINE WHITMOYER (WIFE) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 775 ELMHURST ROAD, SEVERN, MD. 21144 | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) GLEN HAVEN MEMORIAL PARK | | 20c. Location - City or Town, State 8/1/97 GLEN BURNIE, MD. |
| | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Adult respiratory distress syndrome Due to (or as a consequence of): b. bladder cancer Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death 12 days 2 years |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M |
| | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | |
| | 29b. Signature and title of certifier | | 29c. License number RES 000 | | 29d. Date signed (Month, Day, Year) July 30, 1997 |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Nicola Sater Department of Medicine JHBayview Medical Center, Baltimore, MD | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) AUG 01 1997 | | 32. Registrar's Signature | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 25438

Reg. No.

| | | | | | | | | | |
|---|---|---|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Mildred Elizabeth Wilson | | | | 2. Date of Death Month Day Year July 31 1997 | | 3. Time of Death 11:40PM | | |
| | 4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center | | | | 4b. City, Town, or Location of Death Annapolis | | 4c. County of Death Anne Arundel | | |
| Funeral Director | 5. Social Security Number 187-16-2794 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 73 Yrs. | | 8. Date of Birth (Month, Day, Year) Sept. 5, 1923 | | |
| | 9. Birthplace (State or Foreign Country) Pottsville, PA | | 10a. State MD | | 10b. County Anne Arundel | | 10c. City, Town or Location Annapolis | | |
| Usual Residence of Decedent | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 965 Bent Tree Way | | 10f. Zip Code 21401 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker | | 16b. Kind of Business/Industry Housewife | | | | | |
| 17. Father's Name (First, Middle, Last) Wendell Meadows | | | | 18. Mother's Name (First, Middle, Maiden Surname) Dorothy Davis | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Robert F. Wilson, SR. | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 34 Austin Drive, Edgewater, MD 21037 | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Lakemont Memorial Gard. | | Date 8/4/97 | | 20c. Location - City or Town, State Davidsonville, MD | | | |
| 21. Signature of Funeral Service Licensee <i>James M. Taylor</i> | | 22. Name and Address of Facility John M. Taylor Funeral Home, INC. 147 Duke of Gloucester St., Annapolis, MD 21401 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Atherosclerotic Cardiovascular Disease</i> Due to (or as a consequence of): b. <i>Non insulin Diabetes Mellitus</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death 16 yrs 4 yrs. | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>Robert Scott Eden, MD</i> | | 29c. License number D 30701 | | 29d. Date signed (Month, Day, Year) 8-1-97 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Scott Eden, MD, 1410 Forest Dr Annapolis MD 21403 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 06 1997 | | 32. Registrar's Signature <i>John Davidson</i> | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25439

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lola Wilder

2. Date of Death

Month Day Year
July 31, 1997

3. Time of Death

2251

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

245-18-3807

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 12, 1914

9. Birthplace (State or Foreign Country)

Dillon, South Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

10401 Grosvenor Place

10f. Zip Code

20814

10g. Citizen of What Country?

United States
of America

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Nurse

16b. Kind of Business/Industry

(Medical)
Health Care

17. Father's Name (First, Middle, Last)

Joseph Arnette

18. Mother's Name (First, Middle, Maiden Surname)

Blanche Harrelson

19a. Informant's Name/Relationship (Type, Print)

Arnette Hunter/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3 Riverbank Lane, Old Lyme, Connecticut 06371

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Bonaventure Cemetery

Date

Aug. 4,
1997

20c. Location - City or Town, State

Savannah,
Georgia

21. Signature of Funeral Service Licensee

#M00690

Howard A. Cason

22. Name and Address of Facility

Sipples Funeral Home

5525 Abercorn, Savannah, Georgia 31405

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. SUBDURAL HEMATOMA

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

3 DAYS

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
Investigation
2 ☒ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)

JULY 28 97

28b. Time of
Injury

A M

28c. Injury at
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

FELL AT HOME

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

HOME

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

10

29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier

Francis C. Mayle

29c. License number

D 07099

29d. Date signed (Month, Day, Year)

AUGUST 2 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANCIS C MAYLE 10215 FERNWOOD RD BETHESDA MD 20817

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25440

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Sandra S. Watts

2. Date of Death

Aug 4 1997 4:20pm

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

260-56-5974

6. Sex

1 ☐ M ☒ F

7. Age (in yrs. last birthday)

57

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs

Hours Min.

8. Date of Birth

May 13 1940

9. Birthplace (State or Foreign Country)

Georgia

Usual Residence of Decedent

10a. State

MD

10b. County

Queen Annes

10c. City, Town or Location

Stevensville

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

228 State Street

10f. Zip Code

21666

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
White15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

Collage (1-4 or 5+)

1

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Catering

16b. Kind of Business/Industry

Food

17. Father's Name (First, Middle, Last)

Clarence Savage, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Thelma Davis

19a. Informant's Name/Relationship (Type, Print)

Joseph Hickman (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

228 State Street Stevensville, Maryland 21666

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Ft. Lincoln Crematory 8/6/97

Date

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

John M. Taylor Funeral Home, Inc.
147 Duke of Gloucester St. Annapolis, MD 2140123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. acute myocardial infarction
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

immediate

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☒ DOA

Other:

28. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Jeffrey Suggs MD

29c. License number

D28640

29d. Date signed (Month, Day, Year)

Aug 4, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2414 Hightee Ct. Crofton MD 21114

State
Registrar

31. Date filed (Month, Day, Year)

AUG 11 1997

32. Registrar's Signature

Julia Davidson-Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
important: If item 27 is marked other than "natural," or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25441

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|--|---|--|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ROLAND HOWARD WATERS JR. | | | | 2. Date of Death Month Day Year AUGUST 02, 1997 | | 3. Time of Death 12:17 AM | | |
| | 4a. Facility Name (If not institution, give street and number) PRINCE GEORGES HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death CHEVERLY | | 4c. County of Death PRINCE GEORGES | | |
| Funeral Director | 5. Social Security Number 212-13-3344 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 27 Yrs. | | 8. Date of Birth (Month, Day, Year) 12/3/69 | | |
| | 9. Birthplace (State or Foreign Country) Wash., D.C. | | 10a. State Md. | | 10b. County P.G. | | 10c. City, Town or Location Landover | | |
| Usual Residence of Decedent | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 1418 Capital View Terr. | | 10f. Zip Code 20785 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th | | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Merchandising | | 16b. Kind of Business/Industry COCA COLA CO. | | | | | |
| 17. Father's Name (First, Middle, Last) Roland Howard Waters, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname) Margaret Savoy | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Margaret L. Waters/Mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10017 Greenbelt Rd. #304, Lanham, Md. 20706 | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Mem. Park 8/9/97 | | Date 8/9/97 | | 20c. Location - City or Town, State Landover, Md. | | | |
| 21. Signature of Funeral Service Licensee Mary W. Cratt | | | | 22. Name and Address of Facility H.S. Washington & Sons, Inc. 4925 Burroughs Ave., N.E. | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. HEAD INJURIES Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 08-02-97 | | 28b. Time of Injury 12:10A M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred PASSENGER OF AUTO VS FIXED OBJECT COLLISION | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) STREET | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) ARROWICK ARDMORE / PRESTON ST. | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier [Signature] | | 29c. License number DME D33954 | | 29d. Date signed (Month, Day, Year) August 3, 1997 | | | |
| 30. Name and address of person who completed cause of death (from 23a) (Type, Print) MARIO F. GOLIVE JR MD 3001 HOSPITAL DRIVE, CHEVERLY MARYLAND 20785 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 07 1997 | | 32. Registrar's Signature John Anderson-Randall | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25442

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Priscilla Wyatt | | | | 2. Date of Death Month Aug. Day 03 Year 97 | | 3. Time of Death 9:30am | |
| | 4a. Facility Name (If not institution, give street and number) St. Thomas More Nursing & Rehab | | | | 4b. City, Town, or Location of Death Maryland | | 4c. County of Death Prince George | |
| Funeral Director | 5. Social Security Number 260-34-7966 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 90 Yrs. | | 8. Date of Birth (Month, Day, Year) July 13, 1907 | |
| | 9. Birthplace (State or Foreign Country) Newton County | | 10a. State Maryland | | 10b. County Prince George | | 10c. City, Town or Location Hyattsville | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 4922 Lasalle Road | | 10f. Zip Code 20782 | | 10g. Citizen of What Country? United States | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife | | 16b. Kind of Business/Industry None | | | |
| | 17. Father's Name (First, Middle, Last) Sherman Henry Cooper | | 18. Mother's Name (First, Middle, Maiden Surname) Tommie Clack | | 19a. Informant's Name/Relationship (Type, Print) Ann McDonald Neice | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 246 Oneida Street, N.E. Washington, DC 20011 | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery | | 20c. Location - City or Town, State Suitland, Maryland | | 20d. Date Aug 7, 97 | |
| | 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility Latney's Funeral Home, Inc. 3831 Georgia Ave, NW Washington, DC 20011 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Acute Respiratory failure Due to (or as a consequence of): b. Coronary Artery disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | |
| | 28b. Time of Injury M | | 28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier  | | 29c. License number D 22708 | | 29d. Date signed (Month, Day, Year) 8/5/97 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Meer Said Zonozi 1328 Southern Ave, SE Suite 307 Washington, D.C. 20032 | | 31. Date filed (Month, Day, Year) AUG 07 1997 | | 32. Registrar's Signature  | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25443

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last) James Aquilla Windham | | | | 2. Date of Death Month Day Year August 1, 1997 | | 3. Time of Death 11:23 pm | |
| 4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital | | | | 4b. City, Town, or Location of Death Takoma Park | | 4c. County of Death Montgomery | |
| 5. Social Security Number 579-36-4747 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 91 Yrs. | | 8. Date of Birth (Month, Day, Year) May 11, 1906 | |
| 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Prince George's | | 10c. City, Town or Location Adelphi | |
| 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 10523 Pinewood Court | | 10f. Zip Code 20783 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanic | | 16b. Kind of Business/Industry Heating | | 17. Father's Name (First, Middle, Last) Charles Franklin Windham | |
| 18. Mother's Name (First, Middle, Maiden Surname) Margaret Mowatt | | 19a. Informant's Name/Relationship (Type, Print) Carol L. Wilkinson - Daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3056 Centre Road, Riva, Maryland 21140 | | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory | | 20c. Location - City or Town, State Alexandria, Virginia | | 20d. Date 8/4/97 | | 21. Signature of Funeral Service Licensee Claudette J. Gasch | |
| 22. Name and Address of Facility Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 | | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CORONARY ARTERY DISEASE Due to (or as a consequence of): ATHEROSCLEROSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death 10 years 20 years | | 23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | |
| 29a. Signature and title of certifier K. Quinn | | 29c. License number D22910 | | 29d. Date signed (Month, Day, Year) August 2nd 1997 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4700 BERWYN HOUSE RD, COLLEGE PARK MD 20740 | |
| 31. Date filed (Month, Day, Year) AUG 06 1997 | | 32. Registrar's Signature John Duckert-Randall | | State Registrar | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25444

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES ALBERT WARE

2. Date of Death

Month
JULYDay
30Year
1997

3. Time of Death

08:30 AM
FOUND

4a. Facility Name (If not institution, give street and number)

9503 CAPRICE LANE

4b. City, Town, or Location of Death

UPPER MARLBORO

4c. County of Death

PRINCE GEORGES

Funeral
Director

5. Social Security Number

578-38-1595

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Aug. 24, 1921

9. Birthplace (State or Foreign Country)

Greenville, S.C.

Usual Residence of Decedent

10a. State

District of Columbia

10b. County

10c. City, Town or Location

Washington

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

4810 Quarles Street, N.E., #301

10f. Zip Code

20019

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No 4/13/43-

If Yes, Give

Year or Dates: 1/4/46

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

African American

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Retired Information Specialist

16b. Kind of Business/Industry

Government

Department of Defense

17. Father's Name (First, Middle, Last)

George Ware

18. Mother's Name (First, Middle, Maiden Surname)

Eva Burkley

19a. Informant's Name/Relationship (Type, Print)

April D. Yancy - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9503 Caprice Court, Largo, MD 20774

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Lee's Crematory

Date

8/2/97

20c. Location - City or Town, State

Clinton, MD

21. Signature of Funeral Service Licensee

John T. Stewart III

22. Name and Address of Facility

STEWART FUNERAL HOME, Inc.

4001 Benning Road, N. E., Washington, D. C.

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

e. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy

performed?

1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician:2 ☒ Medical Examiner:To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

John T. Stewart III P.M.E.

29c. License number

D33954

29d. Date signed (Month, Day, Year)

JULY 31, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MARIO F. GOLUE JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785

31. Date filed (Month, Day, Year)

AUG 04, 1997

32. Registrar's Signature

John T. Stewart III

State
Registrar

Baltimore, Maryland 21215-0020

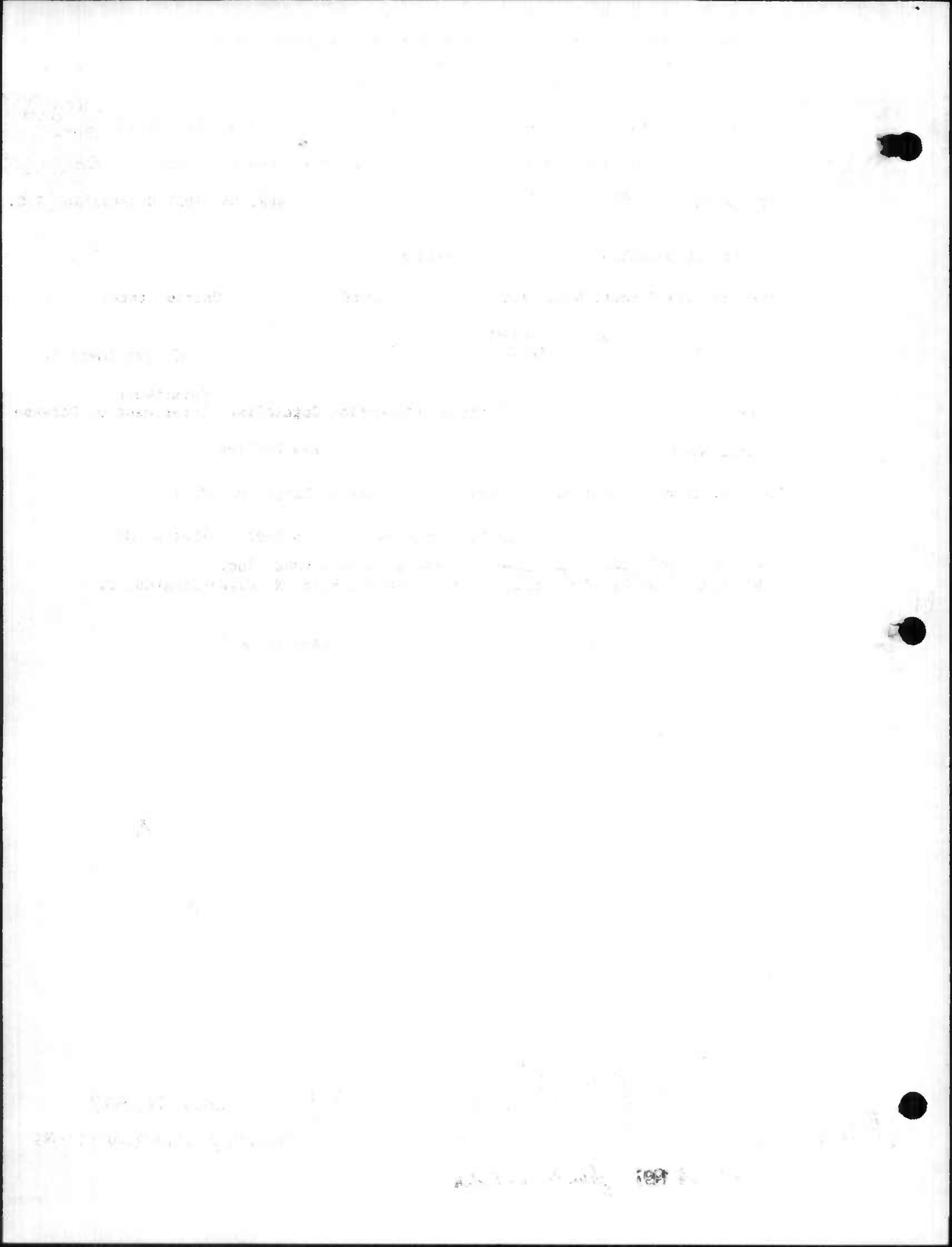
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25445

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MINNIE K. WOODEN

2. Date of Death

Month Day Year
JULY 31, 1997

3. Time of Death

12:30 AM

4a. Facility Name (If not institution, give street and number)

NATIONAL LUTHERAN HOME

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY CO.

5. Social Security Number

220-44-6403

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

99

If Under 1 Year

Months Days

If Under 24 Hrs

Hours Min.

8. Date of Birth

(Month, Day, Year)
MAY 19, 1898

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD.

10b. County

BALTIMORE CITY

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

4532- MARBLE HALL RD.

10f. Zip Code

21239

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

Collage (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

DICTOPHONE OPERATOR

16b. Kind of Business/Industry

UNKNOWN

17. Father's Name (First, Middle, Last)

WILLIAM JONES

18. Mother's Name (First, Middle, Maiden Surname)

BERTHA BISCHOFF

19a. Informant's Name/Relationship (Type, Print)

REV. DR. REICHARD

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9701- VEIRS DR., ROCKVILLE, MD. 20850

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BALTIMORE CEMETERY

Date

8/5/97

20c. Location - City or Town, State

BALTIMORE, MD.

21. Signature of Funeral Service Licensee

W. M. Johnson

22. Name and Address of Facility

HYSONG CO., INC. - 1300-N ST., NW
WASHINGTON, DC

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Severe multi infarct dementia

Due to (or as a consequence of):

b. Anemia

Due to (or as a consequence of):

c. Coronary artery disease

Due to (or as a consequence of):

d. gastrointestinal bleeding

Approximate Interval Between Onset and Death

2 years

3 months

Years

Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Charles W. Karesch

29c. License number

D21726

29d. Date signed (Month, Day, Year)

July 31, 1997

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

DR. CHARLES W. KARESH - 9701- VEIRS DR., ROCKVILLE, MD.

31. Date filed (Month, Day, Year)

AUG 04 1997

32. Registrar's Signature

John Anderson-Randall

State Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25446

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EARL S. WADDY

2. Date of Death

Month Day Year
AUGUST 1, 1997

3. Time of Death

10:11 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

3400 VARNUM STREET

4b. City, Town, or Location of Death

BRENTWOOD

4c. County of Death

PRINCE GEORGES

5. Social Security Number

225-36-7791

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
SEPT. 17, 1931

9. Birthplace (State or Foreign Country)

PENNSYLVANIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

PRINCE GEORGES

10c. City, Town or Location

BRENTWOOD

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3400 VARNUM STREET

10f. Zip Code

20722

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☒ Yes ☐ No
If Yes, Give
Year or Dates: 1953-195513. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
9

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

SELF-EMPLOYED

16b. Kind of Business/Industry

REFUSE REMOVAL

17. Father's Name (First, Middle, Last)

WILLIE WADDY

18. Mother's Name (First, Middle, Maiden Surname)

BLANCHE McCOWIN

19a. Informant's Name/Relationship (Type, Print)

PATRICIA W. WADDY, WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3400 VARNUM STREET, BRENTWOOD, MARYLAND 20722

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

FORT LINCOLN CEMETERY

Date

8/5/97

20c. Location - City or Town, State

BRENTWOOD, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

FORT LINCOLN FUNERAL HOME
3401 BLADENSBURG RD., BRENTWOOD, MARYLAND 2072223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. FAR ADVANCED METASTATIS OF PROSTATE CANCER

YEARS

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24e. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
investigation
☐ Accident ☐ Suicide
☐ Homicide ☐ Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D19250

29d. Date signed (Month, Day, Year)

AUGUST 4, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

JAE S. CHUNG, M.D., 9470 ANNAPOLIS ROAD, SUITE 306, LANHAM, MARYLAND 20706

31. Date filed (Month, Day, Year)

AUG 05 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25447

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Westley Wade, Jr.

2. Date of Death

August 5, 1997

3. Time of Death

6:25am

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

247-48-8368

6. Sex

XXM 2□ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

September 8, 1931

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Seat Pleasant

10d. Inside City Limits

X□ Yes 2□ No

10e. Street and Number

613 64th Place

10f. Zip Code

20743

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1□ Never Married 2X Married

3□ Widowed 4□ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1X Yes 2□ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1□ Yes 2X No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

C. England + Son Trucking

17. Father's Name (First, Middle, Last)

Westley Wade, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Lutisher Johnson

19a. Informant's Name/Relationship (Type, Print)

Mrs. Dorothy E. Wade (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

613 64th Place Seat Pleasant, Maryland 20743

20a. Method of Disposition

XX Burial 2□ Cremation 3□ Removal from State

4□ Donation 5□ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

8/9/97

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Rollins Funeral Home, Inc.

4339 Hunt Place, N.E. Washington, D.C. 20019

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Myocardial Infarction

Due to (or as a consequence of):

b. End Stage Renal disease

Due to (or as a consequence of):

c. Seizure disorder

Due to (or as a consequence of):

d. Hypertension

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Bilateral Above Knee Amputation

23b. Did tobacco use contribute to the cause of death?

1□ Yes 2X No 3□ Probably 4□ Unknown

24a. Was an autopsy performed?

1□ Yes 2X No

24b. Were autopsy findings available prior to completion of cause of death?

1□ Yes 2□ No

N/A

25. Was case referred to medical examiner?

1□ Yes 2X No

Hospital:

1X Inpatient

2□ ER/Outpatient

3□ DOA

26. Place of Death (Check only one)

Other:

4□ Nursing Home

5□ Residence

6□ Other (Specify)

27. Manner of Death

1X Natural

2□ Accident

3□ Suicide

4□ Homicide

5□ Pending investigation

6□ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1□ Yes 2□ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1X Certifying Physician

2□ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D31528

29d. Date signed (Month, Day, Year)

8/6/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Margaret Akpan 6128 Landover Rd. Cheverly Md. 20785

State
Registrar

31. Date filed (Month, Day, Year)

AUG 08 1997

32. Registrar's Signature

John A. Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

1881 1/2 1882

1883 1/2 1884

1885 1/2 1886

1887 1/2 1888

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1921 1/2 1922

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25448

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|---|--|--|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MADGE OPAL YOUNG | | | | 2. Date of Death Month Day Year August 5 1997 | | 3. Time of Death 3:05pm | |
| | 4a. Facility Name (If not institution, give street and number) Physicians Memorial Hospital | | | | 4b. City, Town, or Location of Death La Plata | | 4c. County of Death Charles | |
| Funeral Director | 5. Social Security Number 579-44-8552 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 78 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 6. Date of Birth (Month, Day, Year) MAY 30, 1919 | 9. Birthplace (State or Foreign Country) WASHINGTON, D.C. |
| | Usual Residence of Decedent | | | | 10a. State MARYLAND | | 10b. County PRINCE GEORGES | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 14908 WANNAS DRIVE | | 10f. Zip Code 20607 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER | | 16b. Kind of Business/Industry OWN HOME | | | |
| | 17. Father's Name (First, Middle, Last) MARSHALL BRADY | | | | 18. Mother's Name (First, Middle, Maiden Surname) HELEN DULEY | | | |
| | 19a. Informant's Name/Relationship (Type, Print) JOHN S. YOUNG / SON | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11566 DEER LANE LAPLATA, MARYLAND 20646 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) FORT LINCOLN CEMETERY | | 20c. Location - City or Town, State 8-13-97 BRENTWOOD, MARYLAND | | | |
| | 21. Signature of Funeral Service Licensee Shannon W. Ramirez SHANNON W. RAMIREZ MO0798 | | | | 22. Name and Address of Facility THE HUNTT FUNERAL HOME, INC. P.O. BOX 156 WALDORF, MARYLAND 20604-156 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. CHRONIC OBSTRUCTIVE PULMONARY DISEASE 5 YRS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY DISEASE MALNUTRITION | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier [Signature] | | 29c. License number D - 28281 | | 29d. Date signed (Month, Day, Year) AUGUST 5, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Nelson Benjers, MD 6B Industrial Park Drive, Preston Square II, Waldorf, Maryland 20602 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 12 1997 | | 32. Registrar's Signature [Signature] | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25449

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Chi Yin Yan

2. Date of Death

Month Day Year
July 28, 1997

3. Time of Death

5:50am

4e. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

579-88-1104

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jun 10, 1927

9. Birthplace (State or Foreign Country)

China

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Germantown

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

26 Heighstream Ct

10f. Zip Code

20874

10g. Citizen of What Country?

China

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Oriental

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Tim Koon Gin

18. Mother's Name (First, Middle, Maiden Surname)

Zhen Zhi Ng Yin

19a. Informant's Name/Relationship (Type, Print)

Ruby Chan/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

807 Whitehall St, Silver Spring, MD 20901

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cypress Hill Cemetery

Date

Aug 1/97

20c. Location - City or Town, State

Brooklyn, NY

21. Signature of Funeral Service Licensee

▶ Alan J. Donnell

22. Name and Address of Facility

Hines-Rinaldi Funeral Home

11800 New Hampshire Ave, Silver Spring, MD 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration pneumonia
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive heart failure

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No25. Was case referred to medical examiner?
☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury et Work?

☐ Yes ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

▶ Barry Rosenbaum

29c. License number

DO 9834

29d. Date signed (Month, Day, Year)

July 28 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BARRY ROSENBAUM 3720 FARRAGUT AVE, KEVINGTON, MD 20895

31. Date filed (Month, Day, Year)

JUL 29 1997

32. Registrar's Signature

Julia Davidson-Randall

State
RegistrarDeputy Chief ME J. Tauber, released on July 28, 1997
Baltimore, Maryland 21215-0020To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97-25450

| | | | | | | | | |
|---|--|--|--|--|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Marc Alan Zimmerman | | | | 2. Date of Death Month 7 Day 30 Year 97 | | 3. Time of Death 5:00 AM | |
| | 4a. Facility Name (If not institution, give street and number) 13 Rolling Knoll Court | | | | 4b. City, Town, or Location of Death Gaithersburg | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 216-58-7969 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 46 Yrs. | | 8. Date of Birth (Month, Day, Year) Sept. 15, 1950 | |
| | 9. Birthplace (State or Foreign Country) Illinois | | 10a. State Md. | | 10b. County Montgomery | | 10c. City, Town or Location Gaithersburg | |
| Usual Residence of Decedent | | | | | | | | |
| 10a. State Md. | | | 10b. County Montgomery | | | 10c. City, Town or Location Gaithersburg | | |
| 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 10e. Street and Number 13 Rolling Knoll Court | | | 10f. Zip Code 20877 | | |
| 10g. Citizen of What Country? United States | | | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12 | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Restaurant Owner | | | 16b. Kind of Business/Industry Restaurant | | | 17. Father's Name (First, Middle, Last) Gaylord Zimmerman | | |
| 18. Mother's Name (First, Middle, Maiden Surname) Helen Huls | | | 19a. Informant's Name/Relationship (Type, Print) Leslie A. Zimmerman (Wife) | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13 Rolling Knoll Ct. Gaithersburg, Md. 20877 | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory | | | 20c. Location - City or Town, State Alexandria, Va. | | |
| 21. Signature of Funeral Service Licensee Curtis E. Day | | | 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, Md. 20877 | | | 23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Respiratory failure Due to (or as a consequence of): b. Pulmonary interstitial fibrosis 2 years Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | |
| 28a. Date of Injury (Month, Day, Year) | | | 28b. Time of Injury M | | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier John G. Lodmell MD. | | | 29c. License number D05809 | | |
| 29d. Date signed (Month, Day, Year) July 30 1997 | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John G. Lodmell MD. 2201 OLNEY RD. OLNEY MD 20832 | | | 31. Data filed (Month, Day, Year) AUG 01 1997 | | |
| 32. Registrar's Signature John Davidson-Randall | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25451

Item: 1 per MD G-751 9/16/97 dh

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MELVIN AVERY aka Melvin Green

2. Date of Death

August 15 1997

3. Time of Death

1700 HOURS

4a. Facility Name (If not institution, give street and number)

Saint Agnes HealthCare

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

213-62-4011

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

44 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 15, 1953

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

716 LINNARD STREET

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11th grade

College (1-4 or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Home Improvement

16b. Kind of Business/Industry

Private Business

17. Father's Name (First, Middle, Last)

Willie Green

18. Mother's Name (First, Middle, Maiden Surname)

GLADYS AVERY

19e. Informant's Name/Relationship (Type, Print)

GLADYS WASHINGTON / MOTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

862 McALEER CT Baltimore, Md 21202

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Western Star Ceme.

Date

8/21/97

20c. Location - City or Town, State

Catonville, MD

21. Signature of Funeral Service Licensee

J. Ross Slemmer

22. Name and Address of Facility

CHA TMAN - HARRIS Funeral Home
5340 REISTERSTOWN ROAD
BALTIMORE, MD 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. BACTEREMIA AND SEPTICEMIA

SEVERAL HOURS

Due to (or as a consequence of):

b. BACTERIAL PNEUMONIA, BILATERAL, NECROTIZING

SEVERAL DAYS

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PROBABLE MITRAL ENDOCARDITIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. Ross Slemmer MD

29c. License number

D48054

29d. Date signed (Month, Day, Year)

August 16, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

J. Ross Slemmer, M.D., St. Agnes HealthCare, 900 Caton Ave., Baltimore, MD 21229

31. Date filed (Month, Day, Year)

AUG 22 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

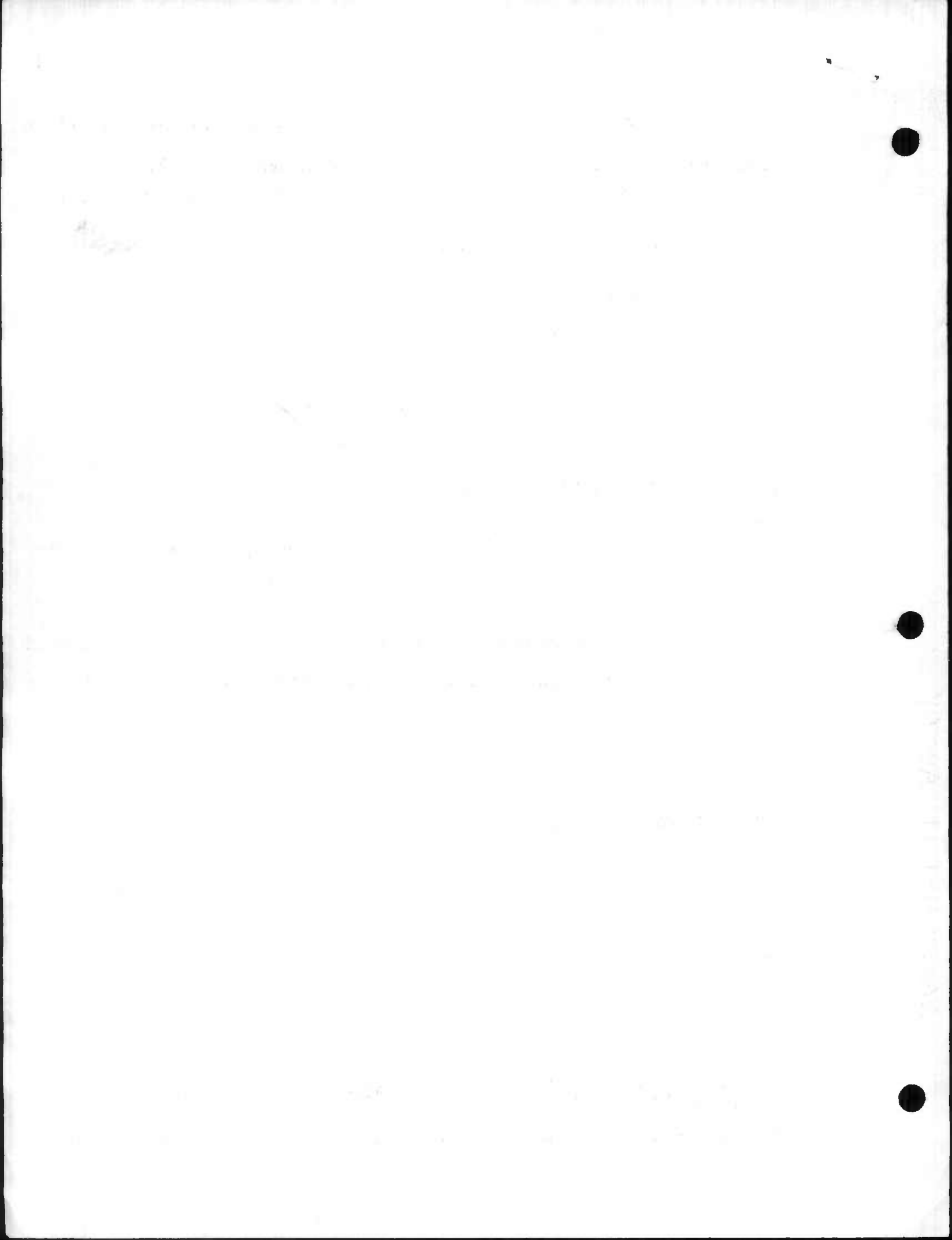
To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit permit.

NAME: MELVIN AVERY



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

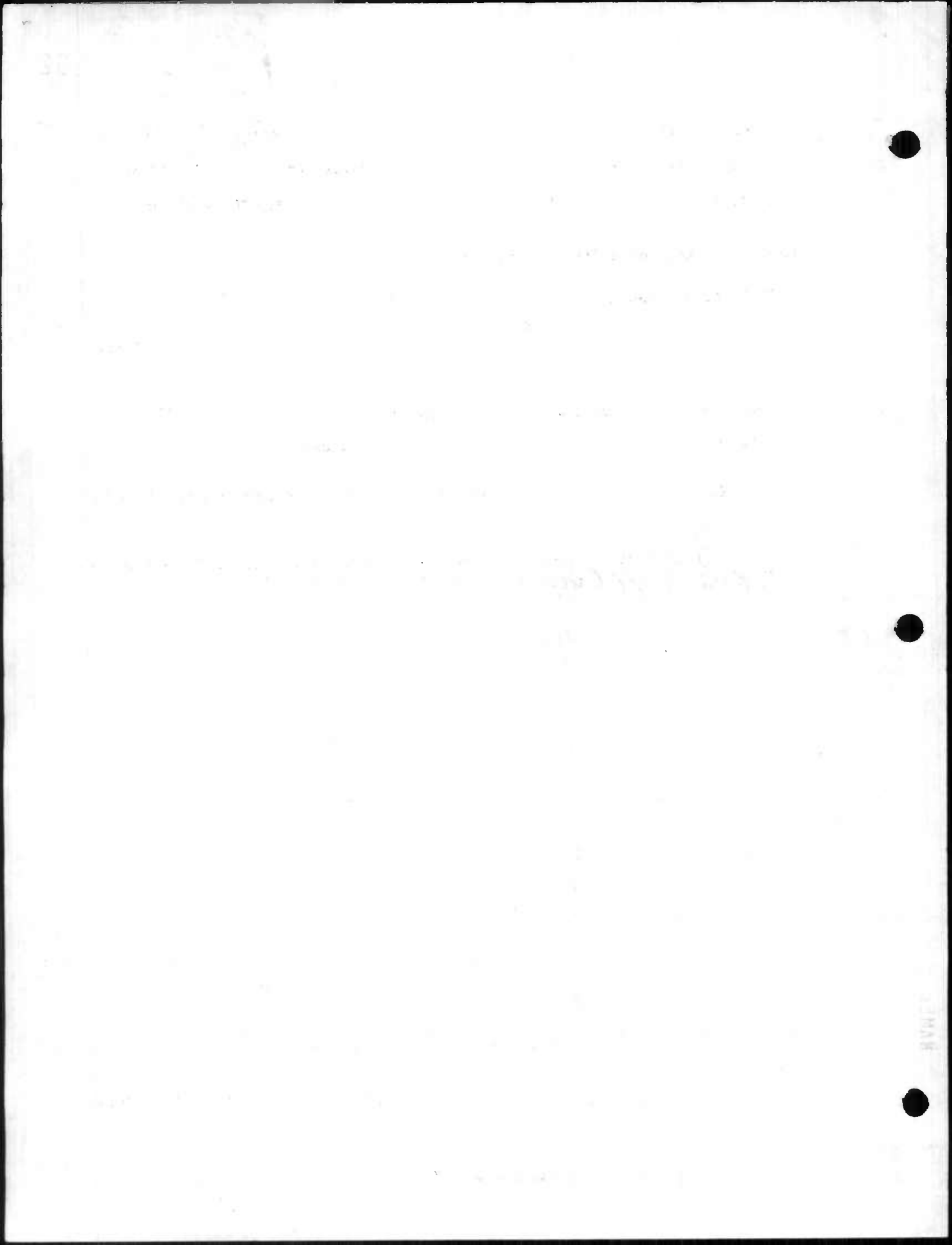
State of Maryland / Department of Health and Mental Hygiene

97 25452

Certificate of Death

Reg. No.

| | | | | | |
|---|---|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Irene Anderson | | 2. Date of Death Month <u>Aug</u> Day <u>1</u> Year <u>1997</u> | | 3. Time of Death <u>02:47</u> |
| | 4a. Facility Name (If not institution, give street and number) St. Agnes Hospital | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death Baltimore City |
| Funeral Director | 5. Social Security Number 219-30-7197 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 96 | 8. Date of Birth (Month, Day, Year) May 30, 1901 | 9. Birthplace (State or Foreign Country) unknown |
| | Usual Residence of Decedent | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | 10b. County Baltimore City | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| | 10e. Street and Number 22 S. Athol Avenue | | 10f. Zip Code 21229 | | 10g. Citizen of What Country? U.S.A. |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | 12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: unknown | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (14 or 5+) unknown | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unknown | | 16b. Kind of Business/Industry unknown |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) unknown | | 18. Mother's Name (First, Middle, Maiden Surname) unknown | | |
| | 19a. Informant's Name/Relationship (Type, Print) Muriel Tucker | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1005 Wallnut Avenue, Baltimore, Maryland 21229 | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201 | | 20c. Location - City or Town, State |
| | 21. Signature of Funeral Service Licensee Ronald S. Wade Director | | 22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201 | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): b. Acute Renal failure Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death 1 week 1 week |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive Heart failure | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M <input type="checkbox"/> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how Injury occurred | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Barry Liberoni MD Resident | | |
| | 29c. License number P10881 | | 29d. Date signed (Month, Day, Year) August 1 1997 | | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barry Liberoni MD 900 caton AVE Baltimore md 21229 | | | | |
| | 31. Date filed (Month, Day, Year) AUG 22 1997 | | 32. Registrar's Signature [Signature] | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25453

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Loretta Inez Bailey

2. Date of Death

Month Day Year
August 20, 1997

3. Time of Death

2:30am

4a. Facility Name (If not institution, give street and number)

Stella Maris

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

234-32-4299

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb 20, 1909

9. Birthplace (State or Foreign Country)

W. Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2300 Dulaney Valley Road

10f. Zip Code

21204

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

n/a

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Owner/Manager

16b. Kind of Business/Industry

Dry Cleaning

17. Father's Name (First, Middle, Last)

William Grant Bailey

18. Mother's Name (First, Middle, Maiden Surname)

Lizzie Chapman

19a. Informant's Name/Relationship (Type, Print)

Phyllis Heater Noble/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10106 Charrington Road, Cockeysville, MD 21030

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Roselawn Mem. Grdns. 8/23/97

Date

20c. Location - City or Town, State

Meadville, PA

21. Signature of Funeral Service Licensee

Bryan W. Clary

22. Name and Address of Facility

Lemmon Funeral Home
10 W. Padonia Road, Timonium, MD 2109323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

ASCVD

b. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and DeathSuper
long

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

George T. Gilmore MD

29c. License number

D02325

29d. Date signed (Month, Day, Year)

8/21/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George T. Gilmore, MD 20 E. Timonium, MR, suite 2211, Timonium, MD 21093

31. Date filed (Month, Day, Year)

AUG 22 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25454

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Anna Virginia Brune

2. Date of Death

Month Day Year
Aug. 16, 1997

3. Time of Death

5:28 P.M.

4a. Facility Name (If not institution, give street and number)

Good Samaritan Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

217-22-0997

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Feb-19-1915

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Md.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2425 E. Madison Street

10f. Zip Code

21205

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

(Unknown) Campbell

18. Mother's Name (First, Middle, Maiden Surname)

Anna (Unknown)

19a. Informant's Name/Relationship (Type, Print)

Albert Brune/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4936 Aberdeen Ave., Baltimore, Md. 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

OakLawn Cemetery 8-21-97

Date

20c. Location - City or Town, State

Balto., Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Moran-Ashton-Dabrowski Funeral Home, Inc.

3000 E. Baltimore St., Balto., Md. 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Inferior Myocardial Infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

End stage renal disease on dialyses

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jihad Roussef, MD

29c. License number

P10584

29d. Date signed (Month, Day, Year)

August 16, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jihad Roussef, MD

Good Samaritan Hospital, 5601 Loch Raven Boulevard, Baltimore, MD., 21239

31. Date filed (Month, Day, Year)

AUG 22 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25455

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|--|--|---|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) John Aaron Brown, Sr. | | | | 2. Date of Death Month Day Year August 16 1997 | | 3. Time of Death 1425 hrs | | |
| | 4a. Facility Name (If not institution, give street and number) 19529 Old York Rd. | | | | 4b. City, Town, or Location of Death White Hall | | 4c. County of Death Baltimore | | |
| Funeral Director | 5. Social Security Number 198-10-4336 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 77 Yrs. | | 8. Date of Birth (Month, Day, Year) Nov. 29, 1919 | | |
| | 9. Birthplace (State or Foreign Country) PA | | 10a. State MD | | 10b. County Baltimore | | 10c. City, Town or Location WHITE HALL | | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State MD | | | 10b. County Baltimore | | | 10c. City, Town or Location WHITE HALL | | | |
| 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | |
| 10e. Street and Number 19529 Old York Rd. | | | | 10f. Zip Code 21161 | | 10g. Citizen of What Country? U.S.A. | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Auto Parts Dealer | | | 16b. Kind of Business/Industry Retail | | |
| 17. Father's Name (First, Middle, Last) Lester W. Brown | | | | 18. Mother's Name (First, Middle, Maiden Surname) Clara Lewis | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Joel D. Brown/Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19832 Graystone Rd., White Hall, MD 21161 | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Stablers Cemetery | | | 20c. Location - City or Town, State Aug. 20, 1997 Parkton, MD | | | |
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349 | | | | | |
| 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Chronic ischemic myocardial disease Due to (or as a consequence of): f. Due to (or as a consequence of): g. Due to (or as a consequence of): h. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death 10 years | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic obstructive pulmonary disease | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier J. Crossan O'Donovan, M.D. | | | | 29c. License number DO 7632 | | 29d. Date signed (Month, Day, Year) August 18, 1997 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Crossan O'Donovan, M.D., 2112 Dundalk Ave, BALTO MD 21222 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 22 1997 | | | | 32. Registrar's Signature Julia Davidson-Randall | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25456

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LILLIAN

WILNER

BRAVER

2. Date of Death

Month

Day

Year

AUGUST 18, 1997

3. Time of Death

4:38PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

5. Social Security Number

216-48-2070

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

JULY 4, 1914

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7 SLADE AVE., APT. 722

10f. Zip Code

21208

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

ISAAC

SHAPIRO

18. Mother's Name (First, Middle, Maiden Surname)

SARAH

KRESTMAN

19a. Informant's Name/Relationship (Type, Print)

GEORGE J. BRAVER (HUS.)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7 SLADE AVE., APT. 722 BALTO., MD 21208

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SHAAREI TFILOH

Date

8/20/1997

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

Scott M. Cutler

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.

8900 REISTERSTOWN RD., PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of):

Multiple myeloma

b.

Due to (or as a consequence of):

Amyloidosis

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Paul Celano, MD

29c. License number

D30929

29d. Date signed (Month, Day, Year)

8/19/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PAUL CELANO, MD 6569 W. Charles ST, BALTIMORE, MD 21204

31. Date filed (Month, Day, Year)

AUG 22 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: This certificate has been signed by the attending physician and completely filled in by the funeral director. page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25457

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|---|---|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>Beulah BROWN</i> | | | | 2. Date of Death Month <i>Aug.</i> Day <i>19</i> Year <i>1997</i> | | 3. Time of Death <i>5:55 AM</i> | |
| | 4a. Facility Name (If not institution, give street and number) <i>St. Agnes Hospital</i> | | | | 4b. City, Town, or Location of Death <i>Balto.</i> | | 4c. County of Death <i>N/A</i> | |
| Funeral Director | 5. Social Security Number <i>215-03-1828</i> | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) <i>93</i> Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) <i>6-29-4</i> | 9. Birthplace (State or Foreign Country) <i>MARYLAND</i> |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State <i>Md.</i> | | 10b. County <i>N/A</i> | | 10c. City, Town or Location <i>BALTIMORE</i> | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number <i>4726 VAN Couver Rd.</i> | | | | 10f. Zip Code <i>21229</i> | | 10g. Citizen of What Country? <i>USA</i> | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <i>BLACK</i> | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>6th</i> College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>SEEM STRESS</i> | | 16b. Kind of Business/Industry <i>HANOVER SHIRT CO.</i> | | |
| 17. Father's Name (First, Middle, Last) <i>UN KNOWN</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <i>FANNIE FITCHETT</i> | | | | |
| 19a. Informant's Name/Relationship (Type, Print) <i>Wanda Kimball-Granddaughter</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4726 VAN Couver Rd. Balto. Md. 21229</i> | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>ARBUSTUS CEMETERY</i> | | 20c. Location - City or Town, State <i>BALTO. MD.</i> | | 20d. Date <i>8/23/97</i> |
| 21. Signature of Funeral Service Licensee <i>Jeff Miller</i> | | | | 22. Name and Address of Facility <i>1639 N. BROADWAY BALTO. MD 21213 JEFF MILLER P.C. FUNERAL HOME & SERVICE</i> | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last a. <i>multi-organ system failure</i> Due to (or as a consequence of): b. <i>Sepsis</i> Due to (or as a consequence of): c. <i>Urinary tract infection</i> Due to (or as a consequence of): d. <i>infected sacral decubitus</i> | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Atrial Fibrillation</i> <i>Hypertensive ASCVD</i> <i>Chronic renal failure</i> | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury <i>M</i> | | 28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier <i>[Signature]</i> | | 29c. License number <i>039587</i> | | 29d. Date signed (Month, Day, Year) <i>8/29/97</i> | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>Dr. Stephen H. H. 3455 Wilkins Ave Suite 305 B.H. Md. 21229</i> | | | | | | | | |
| 31. Date filed (Month, Day, Year) <i>AUG 22 1997</i> | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25458

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Irene M. Briant

2. Date of Death

August 17 1997

Day

Year

3. Time of Death

9:30 PM

4a. Facility Name (If not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

215-14-8617

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 31, 1921

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

England

Usual Residence of Decedent

10e. State
Maryland10b. County
N/A10c. City, Town or Location
Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

704 Deepdene Road

10f. Zip Code

21210

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

China Restoration

16b. Kind of Business/Industry

Self Employed

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Esther Mc Comas

19a. Informant's Name/Relationship (Type, Print)

Anke A. Ehrhardt

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

161 W. 15th Street Apt. 7E New York, New York 10011

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hilltop Service Corp.

Date

8/19/97

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee

Burgee-Henss

22. Name and Address of Facility

Burgee-Henss Funeral Home 21211
3631 Falls Road, Baltimore, Maryland

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Anoxic Encephalopathy
Due to (or as a consequence of):b. Cardiac Arrest
Due to (or as a consequence of):c. Coronary Artery Disease
Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

2 days

40 min

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus. Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Michelle L. Apriado MD

29c. License number

AU 4176435 A9155 August 18, 1997

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michelle L. Apriado MD. Union Memorial Hospital

31. Date filed (Month, Day, Year)

AUG 22 1997

32. Registrar's Signature

John Swanson-Rendall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To be Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death. To be Funeral Director: After this certificate has been signed by the attending physician and confirmed by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25459

Items: 24a, b per MEO G-750 8/22/97 reb

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CLAUDE M. BOWLIN

2. Date of Death

Month Day Year

AUGUST 18, 1997

3. Time of Death

20:20 PM

4a. Facility Name (If not institution, give street and number)

607 SPRING LANE

4b. City, Town, or Location of Death

ESSEX

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

196-18-1342

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Jan. 12, 1924

9. Birthplace (State or Foreign Country)

PA.

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

607 Spring Lane

10f. Zip Code

21221

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Navar Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Building Inspector

16b. Kind of Business/Industry

Baltimore County

17. Father's Name (First, Middle, Last)

Arthur C. Bowlin

18. Mother's Name (First, Middle, Maiden Surname)

Minnie P. Myers

19a. Informant's Name/Relationship (Type, Print)

John P. Bowlin /son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

971 Honeywood Place Baltimore Md. 21221

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith Cemetery 8/23/97 Rossville Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

R. Terry Connelly

22. Name and Address of Facility

Connelly Funeral Home of Essex

300 Mace Ave. Baltimore Md. 21221

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Plut force injuries and Cutting Wounds of Head and Cephalic

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☒ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

Found 8/18/97 2000 HX

28b. Time of Injury

2000 HX

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

home

28d. Describe how injury occurred

subject beaten, cut and asphyxiated

28f. Location (Street and Number of Rural Route Number, City or Town, State) 607 Spring Lane Essex Maryland

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Theodore M. King

29c. License number

OCME

29d. Date signed (Month, Day, Year)

AUGUST 19, 1997

30. Name and address of person who completed cause of death (from 23a) (Type, Print)

THEODORE M. KING

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

AUG 22 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours of death. To the Funeral Director: After this certificate has been signed by the attending physician and completed, it must be given to the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25460

Item:5 per FH G-752 10/24/97 dh

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|--|---|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Rhoda Doris Cummings | | | | 2. Date of Death Month August Day 19 Year 1997 | | 3. Time of Death 10:30 pm | |
| | 4a. Facility Name (If not institution, give street and number) St. Elizabeth's Nursing Home | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 218-05-3816 218-05-3815 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 77 Yrs. | | 8. Date of Birth (Month, Day, Year) Oct. 20, 1919 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10e. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 10e. Street and Number 3300 Benson Avenue | | 10f. Zip Code 21227 | |
| | 10g. Citizen of What Country? United States | | | | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: white | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) homemaker | |
| | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) own home | | | | 17. Father's Name (First, Middle, Last) Henry Zinsmeister | | 18. Mother's Name (First, Middle, Maiden Surname) Grace Beck | |
| | 19a. Informant's Name/Relationship (Type, Print) Donald Zinsmeister, brother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 233409 1002 C2 Green Pine Blvd. W. Palm Beach, FL | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial | | 20c. Location - City or Town, State 8/21 Dorsey, Maryland | |
| | 21. Signature of Funeral Service Licensee Dean D. Imbar | | | | 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Road Arbutus 21227 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. congestive heart failure Due to (or as a consequence of): b. incompetent aortic porcine valve Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death 48 hours one week | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pulmonary fibrosis | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier Kris E. Kuhn, M.D. | | 29c. License number D37464 | | |
| 29d. Date signed (Month, Day, Year) August 20, 1997 | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kris E. Kuhn, M.D. 3421 Benson Ave, Suite 230 Baltimore, MD 21227 | | | | |
| 31. Date filed (Month, Day, Year) AUG 22 1997 | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 25461

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|---|---------------------------------|---|--|--|--|--|--|---|----|----------------------------|--|----------------------------------|--|---------------|----|---------------------------------|----------------|----------------------------------|--|--|--|----|--|--|----|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ELLA MARIE CLARK | | | | 2. Date of Death Month AUGUST Day 18 Year 97 | | 3. Time of Death 16:10 | | | | | | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death BALTIMORE CITY | | | | | | | | | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 216-26-7667 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 57 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) April 16 1940 | | | | | | | | | | | | | | | | | | | | | |
| | 9. Birthplace (State or Foreign Country) North Carolina | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10a. State MD | | 10b. County n/a | | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | |
| 10e. Street and Number 1814 West North Avenue | | | | 10f. Zip Code 21217 | | 10g. Citizen of What Country? USA | | | | | | | | | | | | | | | | | | | | | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | | | | | | | | | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th Grade College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sorter | | 16b. Kind of Business/Industry Superior White House | | | | | | | | | | | | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last) Robert B. Clark | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Barrett | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) sister Barbara J. Williams | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2322 Callow Avenue Baltimore, Maryland 21217 | | | | | | | | | | | | | | | | | | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt Zion Cemetery | | Date Aug 22nd | | 20c. Location - City or Town, State Baltimore, Maryland | | | | | | | | | | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls Parkway Baltimore, MD 21216 | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>e.</td> <td>ANOXIC BRAIN INJURY</td> <td>Approximate Interval Between Onset and Death</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td>2 DAYS</td> </tr> <tr> <td>b.</td> <td>ADENOID CYSTIC CARCINOMA</td> <td>2 YEARS</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td rowspan="2">Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>c.</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table> | | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | e. | ANOXIC BRAIN INJURY | Approximate Interval Between Onset and Death | Due to (or as a consequence of): | | 2 DAYS | b. | ADENOID CYSTIC CARCINOMA | 2 YEARS | Due to (or as a consequence of): | | | Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. | | | d. | | |
| Immediate Cause (Final disease or condition resulting in death) | e. | ANOXIC BRAIN INJURY | Approximate Interval Between Onset and Death | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | 2 DAYS | | | | | | | | | | | | | | | | | | | | | | | | | |
| | b. | ADENOID CYSTIC CARCINOMA | 2 YEARS | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28d. Describe how injury occurred | | | | | | | | | | | | | | | | | | | | | | |
| | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier | | | | | 29c. License number RES-000 | | 29d. Date signed (Month, Day, Year) AUGUST 18 1997 | | | | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) TAMARA DILDY 600 N. WOLFE STREET BALTIMORE MARYLAND | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 22 1997 | | | Registrar's Signature | | | | | | | | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25462

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

FLOYD CALLAWAY

2. Date of Death

August 19 1997

3. Time of Death

0755

4a. Facility Name (If not institution, give street and number)

Church Home Hosp.

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral
Director

5. Social Security Number

220-36-4045

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

12-15-26

9. Birthplace (State or Foreign Country)

Va.

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2128 Cliftwood Ave

10f. Zip Code

21213

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Navar Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

9th grade

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working
life. DO NOT use retired)

Pay Loader

16b. Kind of Business/Industry

Beth. Steel

17. Father's Name (First, Middle, Last)

Elijah Calloway

18. Mother's Name (First, Middle, Maiden Surname)

Otelia Abbitt

19a. Informant's Name/Relationship (Type, Print)

Rose Calloway

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2128 Cliftwood Ave, Balto., MD 212

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Baltimore Cen

Date

8/22/97

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Bernard P. Johnson

22. Name and Address of Facility

March F. H. East 1101 E. North Ave

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.

ADENOCARCINOMA OF THE LUNG, STAGE 4

Approximate
Interval Between
Onset and Death

2 months

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pulmonary Atherosclerosis

Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Bernard P. Johnson M.D. - Specialist

29c. License number

D40356

29d. Date signed (Month, Day, Year)

AUGUST 19, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WENELISA NAVARRO, MD. 100 N. BROADWAY, Baltimore, Maryland 21231

31. Date filed (Month, Day, Year)

AUG 22 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

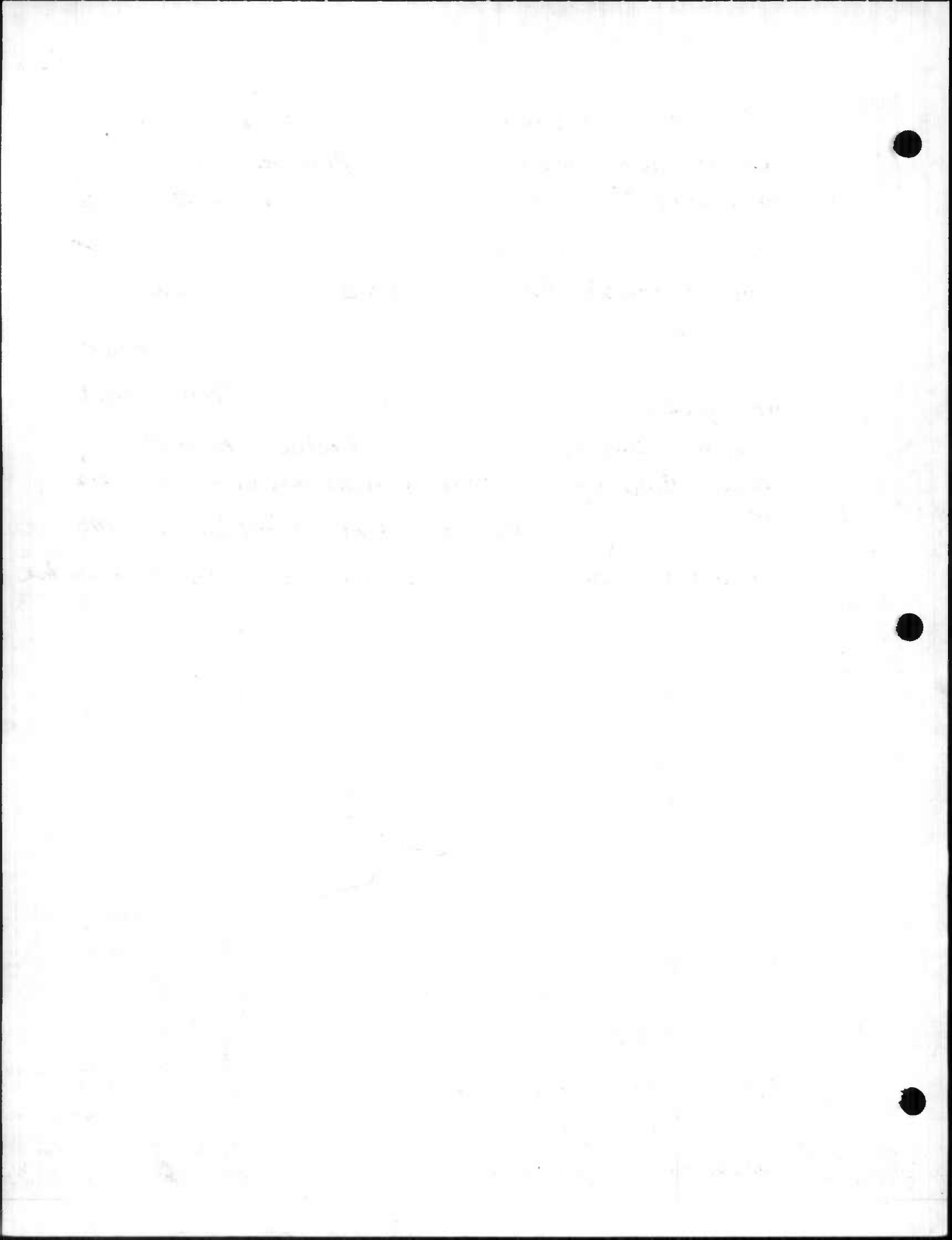
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25463

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|---|---|--|-------------------------|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) John Campbell | | | | 2. Date of Death Month AUGUST Day 18 Year 1997 | | 3. Time of Death 08:25 AM | |
| | 4a. Facility Name (If not institution, give street and number) ST. AGNES HOSPITAL 900 S. CATON AVE | | | | 4b. City, Town, or Location of Death BALTIMORE, MD | | 4c. County of Death | |
| Funeral Director | 5. Social Security Number 217-50-6282 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 48 Yrs. | | 8. Date of Birth (Month, Day, Year) 6-18-49 | |
| | 9. Birthplace (State or Foreign Country) Va. | | 10a. State MD | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 1709 Ingram Rd | | 10f. Zip Code 21239 | | 10g. Citizen of What Country? U.S.A | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th grade | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) News paper Carrier | | 16b. Kind of Business/Industry News paper | | 17. Father's Name (First, Middle, Last) Howard P. Campbell | |
| | 17. Mother's Name (First, Middle, Maiden Surname) Mary Rose | | 19a. Informant's Name/Relationship (Type, Print) Lillian Campbell | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1709 Ingram Rd, Balto, MD 21239 | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place) King MEM Park | | 20c. Date 8-22-97 | | 20d. Location - City or Town, State Randallstown, MD | | 21. Signature of Funeral Service Licensee Bernard R. Johnson | |
| | 22. Name and Address of Facility March F. H. EAST 1101 E. North Ave | | 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Pneumonia Due to (or as a consequence of): Chronic Obstructive Pulmonary Disease | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Piece of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | |
| | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier SK | |
| | 29c. License number D51853 | | 29d. Date signed (Month, Day, Year) 8/18/97 | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Michael Silverman MD St Agnes ED Balt, MD 21229 | | 31. Date filed (Month, Day, Year) AUG 22 1997 | |
| 32. Registrar's Signature Julia Davidson-Randall | | 33. State Registrar AUG 22 1997 | | 34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | | 35. NAME: John Campbell | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.


State of Maryland / Department of Health and Mental Hygiene

Item 23 Part I 8-22-97 Film G750 W.H. Per Doctor

Certificate of Death

Reg. No.

97 25464

| | | | | | | | | | | |
|---|---|---------------------------------|---|---|--|---|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) VIOLET M. DOYLE | | | | | | 2. Date of Death Month Aug Day 16 Year 1997 | | 3. Time of Death 5:30 A.M. | |
| | 4a. Facility Name (If not institution, give street and number) ST. AGNES HOSPITAL | | | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death BALTIMORE | |
| Funeral Director | 5. Social Security Number 212-03-9845 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 81 Yrs. | | 8. Date of Birth (Month, Day, Year) NOV. 26, 1915 | | 9. Birthplace (State or Foreign Country) MD | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State MD | | 10b. County BALTIMORE | | 10c. City, Town or Location CATONSVILLE | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 815 WINTERS LANE APT. 209 | | | | 10f. Zip Code 21228 | | 10g. Citizen of What Country? U.S.A. | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | | 12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) OFFICE WORK | | | 16b. Kind of Business/Industry A&P | | | |
| 17. Father's Name (First, Middle, Last) FRANK K. SLINKMAN | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) MYRTLE A. HAINES | | | | |
| 19a. Informant's Name/Relationship (Type, Print) RALPH DOYLE (SON) | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10201 WEATHERBURN ROAD ELLICOTT CITY MD 21042 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) CRESTLAWN MEM. GARDEN | | | Date 8/19/1997 | | 20c. Location - City or Town, State MARRIOTTSTVILLE MD | | |
| 21. Signature of Funeral Service Licensee  | | | | | | 22. Name and Address of Facility WITZKE FUNERAL HOME, INC. OF COLUMBIA 5555 TWIN KNOLLS ROAD COLUMBIA MARYLAND 21045 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sever Sleep Apnea Pulmonary Hypertension Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Approximate Interval Between Onset and Death 10 days | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | 29b. Signature and title of certifier  H.D. | | | 29c. License number P.O. 9885 | | 29d. Date signed (Month, Day, Year) Aug, 16, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Haytham Bishara M.D. St Agnes Hospital 900 Caton Ave. Baltimore MD 21229 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 22 1997 | | | 32. Registrar's Signature  | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

NAME: DOYLE, VIOLET M.

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25465

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|---|---|---|--|--|---|--|--|---|-------------------------|--|--|--|--|--|--|--|----------------------------------|--|--|--|--|--|--|--|---|---------------------------|--|--|--|--|--|--|----------------|----------------------------------|--|--|--|--|--|--|--|----|--|--|--|--|--|--|--|----------------------------------|--|--|--|--|--|--|--|----|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JAMES DONATI | | | | 2. Date of Death Month Day Year August 19 - 1997 | | 3. Time of Death 12:05 AM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) CHURCH HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 213-09-4215 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (in yrs. last birthday) 81 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 12/24/1915 | 9. Birthplace (State or Foreign Country) MD | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County BALTIMORE | | 10c. City, Town or Location DUNDALK | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 10e. Street and Number 233 COLGATE AVE. | | | | 10f. Zip Code 21222 | | 10g. Citizen of What Country? U.S.A. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PIPE FITTER | | | | 16b. Kind of Business/Industry STEEL CO. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last) SANTINO DONATI | | | | 18. Mother's Name (First, Middle, Maiden Surname) EUFEMIA (UNKNOWN) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) MARIE DONATI / WIFE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 233 COLGATE AVE. DUNDALK, MD 21222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) OAKLAWN CEMETERY | | Date 8/22/97 | | 20c. Location - City or Town, State BALTIMORE, MD | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee Philly Starks | | | | 22. Name and Address of Facility BRADLEY-ASHTON FUNERAL HOME, INC. 2134 WILLOW SPRING ROAD DUNDALK, MD 21222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td colspan="7">e. Renal Failure</td> <td>Approximate Interval Between Onset and Death UNKNOWN</td> </tr> <tr> <td colspan="7">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td rowspan="2">{</td> <td colspan="7">b. NEPHROSCLEROSIS</td> <td>UNKNOWN</td> </tr> <tr> <td colspan="7">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td colspan="7">c. </td> <td></td> </tr> <tr> <td colspan="7">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td colspan="7">d. </td> <td></td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | e. Renal Failure | | | | | | | Approximate Interval Between Onset and Death UNKNOWN | Due to (or as a consequence of): | | | | | | | | { | b. NEPHROSCLEROSIS | | | | | | | UNKNOWN | Due to (or as a consequence of): | | | | | | | | c. | | | | | | | | Due to (or as a consequence of): | | | | | | | | d. | | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | e. Renal Failure | | | | | | | Approximate Interval Between Onset and Death UNKNOWN | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | { | b. NEPHROSCLEROSIS | | | | | | | | UNKNOWN | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier Juan A. Surriel | | 29c. License number D23023 | | | | 29d. Date signed (Month, Day, Year) 8/20/97 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUAN A. SURIEL MD. CHURCH HOME HOSPITAL BALTO. MD. 21230 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 22 1997 | | 32. Registrar's Signature Julia Davidson-Randall | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

NAME KNOWN TO PHYSICIAN
James Donati
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

MICHAEL

State of Maryland / Department of Health and Mental Hygiene

97 25467

DiANGELO Items: 23a part I, 27, 28a-f per MEO G-751 9/2/97

dh

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MICHAEL UMBERTO DiANGELO | | | | 2. Date of Death Month Day Year AUGUST 19 1997 | | 3. Time of Death 11:00A.M. | |
| | 4a. Facility Name (If not institution, give street and number) 8733 PULASKI HWY | | | | 4b. City, Town, or Location of Death ESSEX | | 4c. County of Death BALTIMORE | |
| Funeral Director | 5. Social Security Number 217-58-5114 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 45 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 01/03/1952 | | 9. Birthplace (State or Foreign Country) MD |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | 10b. County HOWARD | 10c. City, Town or Location MT. AIRY | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number 16404 OLD FREDERICK ROAD | | | | 10f. Zip Code 21771 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4or 5+) 2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PLUMBERS HELPER | | 16b. Kind of Business/Industry PLUMBING | | | |
| | 17. Father's Name (First, Middle, Last) MARION DiANGELO | | | | 18. Mother's Name (First, Middle, Maiden Summa) CATHERINE D. THORN | | | |
| | 19a. Informant's Name/Relationship (Type, Print) MARION DiANGELO/ FATHER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16404 OLD FREDERICK ROAD MT. AIRY, MD 21771 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) CRESTLAWN MEMORIAL GARDEN 8/23/97 | | Data | | 20c. Location - City or Town, State MARIOTTSTVILLE, MD | |
| | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility STERLING ASHTON FUNERAL HOME, INC. 736 EDMONDSON AVE. CATONSVILLE, MD 21228 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. NARCOTIC AND ALCOHOL INTOXICATION Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) MOTEL | | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) found: 8/19/97 | | 28b. Time of Injury found: 10:54 | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | 28d. Describe how injury occurred unknown | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) 8733 Pulaski Highway, Baltimore County, Md. | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) AUGUST 20, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David R Fowler 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 22 1997 | | 32. Registrar's Signature | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25468

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Katherine C. Ekr

2. Date of Death

August 20 1997

3. Time of Death

11:10AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Franklin Woods Nursing Center

4b. City, Town, or Location of Death

Rossville

4c. County of Death

Baltimore

5. Social Security Number

213-72-2420

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 1, 1909

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

295 Montrose Avenue

10f. Zip Code

21221

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

UNEDOWN

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

William Laib

18. Mother's Name (First, Middle, Maiden Surname)

Katherine Bucking

19a. Informant's Name/Relationship (Type, Print)

Frank Ekr (HUSBAND)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

295 Montrose Avenue Essex, Maryland 21221

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Zion Lutheran Cemetery 8/23/1997

Date

20c. Location - City or Town, State

Baltimore Co., Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bruzdinski Funeral Home P.A.

1407 Old Eastern Avenue Essex, Md. 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ATHEROSCLEROTIC - HYPERTENSIVE CARDIOVASCULAR DISEASE

Approximate Interval Between Onset and Death

210 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RENAL FAILURE

ASPIRATION PNEUMONIA

COLON CARCINOMA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day Year)

28b. Time of injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D15022

29d. Date signed (Month, Day, Year)

August 21, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

8552 PHILADELPHIA RD., BALTIMORE, MD 21237

31. Date filed (Month, Day, Year)

AUG 22 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

T

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25469

Items 10b, 10c 9-8-97 Film G751 W.H. Per F/R

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|--|---|---|--|---|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Simpson Fant | | | | 2. Date of Death Month Day Year August 17, 1997 | | | | 3. Time of Death 3:45 p.m. | |
| | 4a. Facility Name (If not institution, give street and number) 2929 Fairview Road | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 211-09-8968 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 80 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | |
| | 8. Date of Birth (Month, Day, Year) Oct. 15, 1916 | | 9. Birthplace (State or Foreign Country) S.C. | | 10a. State Md. | | 10b. County N/A | | 10c. City, Town or Location Woodlawn | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 2929 Fairview Road | | 10f. Zip Code 21207 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed) High School | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Rigger | | 16b. Kind of Business/Industry Bethlehem Steel | | | | | |
| | 17. Father's Name (First, Middle, Last) Simpson Fant | | | | 18. Mother's Name (First, Middle, Maiden Summa) Lizzie Swindler | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) wife Elsie S. Fant (Fantt) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2929 Fairview Road Baltimore, Md. 21207 | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Memorial Park | | Data Aug. 21 | | 20c. Location - City or Town, State Baltimore, Md. | | | |
| | 21. Signature of Funeral Service Licensee Herbert E. Nutter | | | | 22. Name and Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) a. METASTATIC CANCER FROM PANCREAS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death 2 years | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA | | Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Michael Pilman | | 29c. License number D13999 | | 29d. Date signed (Month, Day, Year) 8-19-97 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Michael Pilman 5400 Old Court Road Randallstown, Maryland 21133 | | | | 31. Data filed (Month, Day, Year) AUG 22 1997 | | | | 32. Registrar's Signature Judith Davidson-Randall | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

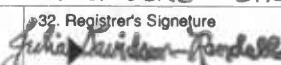
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25470

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) CARL FRALEY | | | | 2. Date of Death Month Day Year AUGUST 16 1997 | | 3. Time of Death 10:20 AM | |
| | 4a. Facility Name (If not institution, give street and number) VETERANS ADMINISTRATION MEDICAL CENTER | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death BALTIMORE | |
| Funeral Director | 5. Social Security Number 234-46-7444 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 87 Yrs. | | 8. Date of Birth Month Day Year 5/15/1910 | |
| | 9. Birthplace (State or Foreign Country) U.S.A. | | 10a. State MD | | 10b. County ANNE ARUNDEL | | 10c. City, Town or Location GLEN BURNIE | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 322 DELEWARE AVENUE | | 10f. Zip Code 21060 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1940-1964 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MILITARY | | 16b. Kind of Business/Industry GOVERNMENT | | | |
| | 17. Father's Name (First, Middle, Last) ANDY FRALEY | | | | 18. Mother's Name (First, Middle, Maiden Surname) MARY ANDERSON | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) MARIAN M. FRALEY - WIFE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 322 DELEWARE AVE., GLEN BURNIE, MD 21060 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) CROWNSVILLE VET. CEM. | | 20c. Location - City or Town, State 8/20/97 CROWNSVILLE, MD | | 20d. Date | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility RAYMOND C. FINK FUNERAL HOME 426 CRAIN HWY., SW., GLEN BURNIE, 21061 | | | |
| | 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. SEPSIS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | Approximate Interval Between Onset and Death 3 WEEKS | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier  | | | | 29c. License number AV 4176435 | | 29d. Date signed (Month, Day, Year) AUGUST 16 1997 | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) CHRISTINA LI 22 SOUTH GREENE STREET BALTIMORE MD 21201 | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 31. Date filed (Month, Day, Year) AUG 22 1997 | | | | 32. Registrar's Signature  | | | |
| | State Registrar | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 25471

Reg. No.

| | | | | | | | | |
|---|---|--|---|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Andre Fitzhugh | | | | 2. Date of Death Month 8 Day 18 Year 97 | | 3. Time of Death 6:15 PM | |
| | 4a. Facility Name (If not institution, give street and number) EN+RC 2525 W. Belvedere Ave. | | | | 4b. City, Town, or Location of Death BALTO, M.D. | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 244-58-8987 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 46 Yrs. | | 8. Date of Birth (Month, Day, Year) JUNE 22, 1951 | |
| | 9. Birthplace (State or Foreign Country) MARYLAND | | 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 5607 Wayne Ave | | 10f. Zip Code BALTO, MD. 21207 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th grade | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CARPENTER | | 16b. Kind of Business/Industry ATLANTIC BUILDERS | | | |
| | 17. Father's Name (First, Middle, Last) Albert Fitzhugh | | | | 18. Mother's Name (First, Middle, Maiden Surname) Marie Jones | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Diane Fitzhugh / wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5607 Wayne Ave Baltimore, Md 21207 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) KING MEMORIAL PARK | | 20c. Date 8/13/97 | | 20d. Location - City or Town, State RANDALLSTOWN, MD | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee Sam Harris | | 22. Name and Address of Facility CHATMAN - HAMM Funeral Home 5340 ROOSTERSTOWN ROAD BALTIMORE, MARYLAND 21215 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. cardiac arrest Due to (or as a consequence of): b. end stage renal disease Due to (or as a consequence of): c. diabetes mellitus Due to (or as a consequence of): d. | | | | | | | Approximate Interval Between Onset and Death minutes years years |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. anemia hypertension | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier Don W Miller | | 29c. License number D07421 | | 29d. Date signed (Month, Day, Year) 8/18/97 | | | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Louis W. Miller MD 1838 Greentree Rd #300 21208 | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) AUG 22 1997 | | 32. Signature of Registrar [Signature] | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,


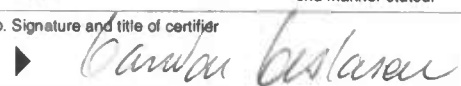
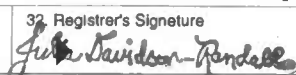
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25472

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Gladys FISCHER | | | | 2. Date of Death Month Day Year August 19, 1997 | | 3. Time of Death 8:10 P.M. | |
| | 4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center | | | | 4b. City, Town, or Location of Death Rosedale | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 220-16-6764 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 73 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 7-23-24 | 9. Birthplace (State or Foreign Country) MD | |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County Baltimore | | 10c. City, Town or Location Rosedale | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 7879 Oakdale Ave. | | | | 10f. Zip Code 21237 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unk. College (1-4or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales Person | | 16b. Kind of Business/Industry Rosedale Pharmacy | | |
| 17. Father's Name (First, Middle, Last) John S. Whisner | | | | 18. Mother's Name (First, Middle, Maiden Surname) Cora M. Gordon | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Carol Beard / daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7875 Oakdale Ave., Rosedale, MD 21237 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill | | Date 8-23-97 | | 20c. Location - City or Town, State Middle River, MD | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Cvach/Rosedale Funeral Home 1211 Chesaco Ave., Rosedale, MD 21237 | | | | |
| 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | Approximate interval Between Onset and Death 8 days | |
| Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of injury (Month, Day Year) | | 28b. Time of injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number D 48185 | | 29d. Date signed (Month, Day, Year) August 19, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Gardar Gislason 9000 Franklin Square Dr. Baltimore, Maryland 21237 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 22 1997 | | | | 32. Registrar's Signature  | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Items 1, 4b, 17 9-9-97 Film G751 W.H. Per Doctor & F/H

State of Maryland / Department of Health and Mental Hygiene

97 25473

Item 2: per MD G-750 8/22/97 dh

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Henry Joseph Hopkins

2. Date of Death Aug. 20, 1997

3. Time of Death 11:30pm

4a. Facility Name (If not institution, give street and number)

St. Agnes Nursing Home

4b. City, Town, or Location of Death

Ellicott City

4c. County of Death

Howard

Funeral
Director

5. Social Security Number

705-10-9901

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 9, 1907

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Lansdowne

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

151 Elizabeth Avenue

10f. Zip Code

21227

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

clerk

16b. Kind of Business/Industry

railroad

17. Father's Name (First, Middle, Last)

Irving Irvin Clay Hopkins

18. Mother's Name (First, Middle, Maiden Surname)

Lucy Estelle Coale

19a. Informant's Name/Relationship (Type, Print)

Joan N. Reece, daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9450 Garnett Lane Ellicott City, MD 21042

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Memorial

Date

8/25

20c. Location - City or Town, State

Dorsey, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Ambrose Funeral Home of Lansdowne
2719 Hammonds Ferry Road 21227

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Pneumonia

Due to (or as a consequence of):

b. Parkinson's

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

days
years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D460193

29d. Date signed (Month, Day, Year)

Aug 22 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Cecilia T. Young 9501 Old Annapolis Rd Suite 200 Ellicott City 21042

31. Date filed (Month, Day, Year)

AUG 22 1997

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25474

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|---|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) CHARLES W. HAMMOND | | | | 2. Date of Death Month Day Year AUGUST 20, 1997 | | 3. Time of Death 3:01 P | |
| | 4a. Facility Name (If not institution, give street and number) SPARROWS POINT | | | | 4b. City, Town, or Location of Death N/A | | 4c. County of Death BALTIMORE | |
| Funeral Director | 5. Social Security Number 218-46-2490 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 49 Yrs. | | 8. Date of Birth (Month, Day, Year) 6-3-48 | |
| | 9. Birthplace (State or Foreign Country) MD | | 10a. State MD | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 5620 East Ave. | | 10f. Zip Code 21206 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Vietnam | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Operating Engineer | | 16b. Kind of Business/Industry Keebler Thompson | | | |
| | 17. Father's Name (First, Middle, Last) Louis Hammond | | | | 18. Mother's Name (First, Middle, Maiden Surname) Gertrude V. Behe | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Linda Hammond / wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5620 East Ave. Baltimore, MD 21206 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith | | 20c. Location - City or Town, State 8-25-97 Baltimore, MD | | | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee Dennis J. Kelly | | | | 22. Name and Address of Facility Cvach/Rosedale Funeral Home 1211 Chesaco Ave, Rosedale, MD 21237 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | Approximate Interval Between Onset and Death | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) WORK | | | |
| | 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 8/20/97 | | 28b. Time of Injury 1435 PM | | 28c. Injury at Work? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred subject struck by falling slag | | | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) building | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) Sparrows Point, MD | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier Dennis J. Chute MD | | | |
| | 29c. License number OCME | | | | 29d. Date signed (Month, Day, Year) AUGUST 21, 1997 | | | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dennis J. Chute MD | | | | 31. Date filed (Month, Day, Year) AUG 22 1997 | | | |
| | 32. Signature of Registrar John Davidson-Rodella | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25475

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Charles L Huselton

2. Date of Death

Month
AugustDay
17Year
1997

3. Time of Death

6 56 PM

4a. Facility Name (If not institution, give street and number)

Mercy Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

577-20-4798

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
10-19-22

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Middle River

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

207 Middleway Rd. Apt. 2B

10f. Zip Code

21220

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
8College (13-16)
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Chauffeur

16b. Kind of Business/Industry

B.G.E.

17. Father's Name (First, Middle, Last)

Charles Huselton

18. Mother's Name (First, Middle, Maiden Surname)

Helen Maddigan

19a. Informant's Name/Relationship (Type, Print)

Chris Reedy / son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8605 Delege Rd., Baltimore, MD 21237

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest V.A.

Date

8-22-97

20c. Location - City or Town, State

Owings Mills, MD

21. Signature of Funeral Service Licensee

Dennis S. Kelly

22. Name and Address of Facility

Cvach/Rosedale Funeral Home
1211 Chesaco Ave., Rosedale, MD 21237

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

7d

Sequentially list conditions, if any, leading to Immediate Cause (Disease or injury that initiated events resulting in death) Last

b. S/P (b) General Pericardial Artery Bypass Graft

Due to (or as a consequence of):

7d

c. Pericardial Vascular Disease

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus COPD

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

L. Thomas Chin MD

29c. License number

P 06757

29d. Date signed (Month, Day, Year)

August 19, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

L. THOMAS CHIN, MD 301 ST. PAUL PLACE, BALTIMORE, MD 21202

31. Date filed (Month, Day, Year)

AUG 22 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed by a hospital or attending physician. The law requires that the attending physician and the funeral director sign this certificate. After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit certificate and filed in by the funeral director.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25476

Item 10c 8-26-97 Film G750 W.H.Per F/H

Item 5 per FH G-750 8/29/97 dh

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|---|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Francis Richard Hanahoe | | | | 2. Date of Death Month Aug Day 19 Year 1997 | | 3. Time of Death 6:45AM | |
| | 4a. Facility Name (If not institution, give street and number) 1523 Shore Drive | | | | 4b. City, Town, or Location of Death Edgewater | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 216-28-6657 | | 8. Sex: <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 60 Yrs. | | 6. Date of Birth (Month, Day, Year) Aug 30 1936 | |
| | 9. Birthplace (State or Foreign Country) PA | | 10a. State MD | | 10b. County Anne Arundel | | 10c. City, Town or Location Arnold Edgewater | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | 10d. inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 10e. Street and Number 1523 Shore Drive | | | | 10f. Zip Code 21037 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th | | College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Landscaping | | 16b. Kind of Business/Industry Lawn Service | |
| | 17. Father's Name (First, Middle, Last) Ambrose Robert Hanahoe | | | | 18. Mother's Name (First, Middle, Maiden Surname) Lydia Mixell | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Ginger Hanahoe/dau in law | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21108 1588 Millersville Rd., Millersville Md | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cem | | Date 8/22 1997 | | 20c. Location - City or Town, State Crownsville Md | |
| | 21. Signature of Funeral Services Licensee <i>Thomas Handley</i> | | | | 22. Name and Address of Facility Hardesty Funeral Home, P.A., 12 Ridgely Ave Annapolis, Md 21401 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. out all cancer surgery Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death 9m | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier <i>Ally P. Williams</i> | | | | 29c. License number 008118 | | 29d. Date signed (Month, Day, Year) 8/19/97 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stanley Watkins M.D., 900 Bestgate Rd., Annapolis, Md 21401 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 22 1997 | | | | 32. Registrar's Signature <i>Julia Davidson-Randall</i> | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25477

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

C. Mack Hickman

2. Date of Death

August 20 1997 12:46 PM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Laurel Regional Hospital

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George

5. Social Security Number

405 72 8785

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

48

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Jan 2 1949

9. Birthplace (State or Foreign Country)

Tx

Usual Residence of Decedent

10a. State

Md

10b. County

Howard

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9592 Canterbury Riding

10f. Zip Code

20723

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Engineer

16b. Kind of Business/Industry

Computers

17. Father's Name (First, Middle, Last)

Marion Lee Hickman

18. Mother's Name (First, Middle, Maiden Surname)

Helen Carr

19a. Informant's Name/Relationship (Type, Print)

Marion Lee Hickman/father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1301 Odenton Rd., Odenton, Md 21113

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Epiphany Episc. Cem.

Date

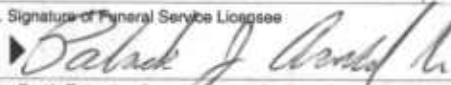
8/25

1997

20c. Location - City or Town, State

Odenton, Md

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Hardesty Funeral Home, P.A., 12 Ridgely Ave., Annapolis, Md 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Massive Pulmonary Embolism Bilateral

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Hypertrophic

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

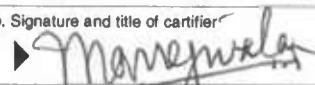
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D13671

29d. Date signed (Month, Day, Year)

8.20.97

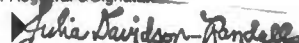
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

B B Manejwala MD 14201 Laurel Park Dr Laurel, Md 20707

31. Date filed (Month, Day, Year)

AUG 22 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25478

Item: 20b per FH G-750 8/22/97 dh

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Carroll Gordon Josselyn

2. Date of Death

Month

Day

Year

August

20

1997

3. Time of Death

04:45 AM

4a. Facility Name (If not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

218-03-8385

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

July 25, 1917

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1112 Concordia Drive

10f. Zip Code

21286

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: 1942

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

CPA - Accountant

16b. Kind of Business/Industry

Accounting

17. Father's Name (First, Middle, Last)

Elmer Howard Josselyn, Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Mabel E. Eccleston

19a. Informant's Name/Relationship (Type, Print)

John H. Josselyn

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8108 Kirkwall Court, Towson, MD 21286

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Carroll Crematory

Date

8/26/97

Aug. 23, 1997

20c. Location - City or Town, State

Hampstead, MD

21. Signature of Funeral Service Licensee

Lowell M. Lemmon

22. Name and Address of Facility

Lemmon Funeral Home

10 W. Padonia Rd., Timonium, MD 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a.

Haemorrhagic Shock

5 hours

Due to (or as a consequence of):

b.

Massive Gastric Intestinal Bleeding

5 hours

Due to (or as a consequence of):

c.

possible Disseminated Intravascular Coagulation

5 hours

Due to (or as a consequence of):

d.

Metastatic Prostate Cancer

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pulmonary Embolism

Metastatic Prostate Carcinoma

Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings

available prior to

completion of cause

of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☒ Yes 2 ☐ No

28. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier
(Check only
one)☒

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. J. S. S.

29c. License number

AT2438946-M17

29d. Date signed (Month, Day, Year)

August 20, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

PEIOTING GAO The Union Memorial Hospital, Baltimore, Maryland 21218

31. Date filed (Month, Day, Year)

AUG 22 1997

32. Registrar's Signature

Julia Davidson-Rendall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25479

Item:10e per FH G-750 8/22/97 dh

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ada E. Keil

2. Date of Death

Month Day Year
Aug. 20, 1997

3. Time of Death

10:30am

4a. Facility Name (If not institution, give street and number)

4302 Ridge Avenue

4b. City, Town, or Location of Death

Halethorpe

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

218-03-9785

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb. 8, 1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State
Maryland10b. County
Baltimore10c. City, Town or Location
Catonsville

10d. Inside City Limits

☐ Yes ☒ No10e. Street and Number
288 Bloomsbury Avenue

10f. Zip Code

21228

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
white15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Circuit Board Assembler

16b. Kind of Business/Industry

Defense Industry

17. Father's Name (First, Middle, Last)

John J. Dougherty

18. Mother's Name (First, Middle, Maiden Surname)

Cora Neuschafer

19a. Informant's Name/Relationship (Type, Print)

Anna Dougherty, sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4302 Ridge Avenue Halethorpe, Maryland 21227

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metro Crematory

Date

8/21

20c. Location - City or Town, State

Catonsville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ambrose Funeral Home, Inc.
1328 Sulphur Spring RoadArbutus
2122723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Metastatic Colon Cancer

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
Investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and Title of Certifier

29c. License number

D44243

29d. Date signed (Month, Day, Year)

August 20, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JW Cook IV MD 1518 Sulphur Spring Rd Arbutus MD 21227

31. Date filed (Month, Day, Year)

AUG 22 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25480

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | | | | |
|--|--|---|--|---|--------------------------------|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last) Andrew Kochen | | | | 2. Date of Death Month August Day 22 Year 1997 | | | | 3. Time of Death 3:04 AM | |
| 4a. Facility Name (If not institution, give street and number) Manor Care Health Care | | | | 4b. City, Town, or Location of Death Rossville | | | | 4c. County of Death Baltimore | |
| 5. Social Security Number 212-07-7182 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 85 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Mar 10 1912 | | 9. Birthplace (State or Foreign Country) Maryland | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State Md. | | 10b. County Baltimore | | 10c. City, Town or Location Dundalk | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 1899 August Ave | | | | 10f. Zip Code 21222 | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Supervisor | | | 16b. Kind of Business/Industry Defense | | |
| 17. Father's Name (First, Middle, Last) Joseph Kochen | | | | 18. Mother's Name (First, Middle, Maiden Surname) Anna Lipovsky | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Robert Kochen / son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7800 Bennerton Drive Baltimore, Md 21236 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Cem. Sacred Heart of Mary 8-25-97 Baltimore, Md | | 20c. Location - City or Town, State | | | |
| 21. Signature of Funeral Service Licensee Anthony C. Connelly | | | | 22. Name and Address of Facility Connelly Funeral Home of Dundalk 7110 Sollers Point Rd 21222 | | | | | |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>immediate Cause (Final disease or condition resulting in death)</p> <p>a. ASCVD Due to (or as a consequence of):</p> <p>b. Parkinsonism Due to (or as a consequence of):</p> <p>c. Hypertension Due to (or as a consequence of):</p> <p>d.</p> </div> <div style="width: 35%;"> <p>Approximate Interval Between Onset and Death</p> <p>> 5 years</p> <p>> 1 year</p> <p>> 5 years</p> </div> </div> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | |
| | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. Signature and title of certifier [Signature] | | | | 29c. License number 042736 | | 29d. Date signed (Month, Day, Year) 8-22-97 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 7600 Osler Drive Towson Md 21204 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 22 1997 | | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25481

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Beulah C. Kerin

2. Date of Death

Month Day Year
August 16, 1997

3. Time of Death

9:00 AM

4a. Facility Name (If not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

210-28-5197

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

65

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Aug. 16, 1932

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

805 W. 38th Street

10f. Zip Code

21211

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Miles Van Horn

18. Mother's Name (First, Middle, Maiden Surname)

Myrtle Perryman

19a. Informant's Name/Relationship (Type, Print)

George Kerin Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

805 W. 38th Street, Baltimore, Maryland 21211

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Druid Ridge Cemetery

Date

8/19/97

20c. Location - City or Town, State

Pikesville, Maryland

21. Signature of Funeral Service Licensee

Burgee-Henss

22. Name and Address of Facility

Burgee-Henss Funeral Home 21211
3631 Falls Road, Baltimore, Maryland

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or organ failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. RESPIRATORY FAILURE
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CHRONIC OBSTRUCTIVE PULMONARY
Due to (or as a consequence of):c. DISEASE
Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

45 days

75 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Burgee-Henss

29c. License number

D20111

29d. Date signed (Month, Day, Year)

AUGUST 10 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROSA E. SYAKI UNION MEMORIAL HOSP. BAL. MD 21218

31. Date filed (Month, Day, Year)

AUG 22 1997

State
RegistrarBaltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitKerin, Beulah.
Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 25482

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Josephine Marie Kinlein

2. Date of Death

Month Day Year
August 17 1997

3. Time of Death

8:16 AM

4a. Facility Name (If not institution, give street and number)

Fallston General Hospital

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

216-20-3761

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 10, 1925

9. Birthplace (State or Foreign Country)

Baltimore Co., Md.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Bradshaw

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8029 Bradshaw Road

10f. Zip Code

21021

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:
White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12 Yrs.

College (14 or 5+)
n/a

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Blue Cross/Blue Shield

17. Father's Name (First, Middle, Last)

Joseph Kinlein

18. Mother's Name (First, Middle, Maiden Surname)

Anna Marie Devers

19a. Informant's Name/Relationship (Type, Print)

Mrs. Magdalena D. Harper (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

114 Helena Drive Prince Frederick, Md. 20678

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery

Date

8/21/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

E. F. Lassahn

22. Name and Address of Facility

E. F. Lassahn Funeral Home
11750 Belair Road Kingsville, Md. 21087

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *adult respiratory distress syndrome*
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

< 2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David S. Dunn

29c. License number

D32295

29d. Date signed (Month, Day, Year)

August 17, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DAVID S. DUNN 615 West MacPhail

31. Date filed (Month, Day, Year)

AUG 22 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Kinlein, Josephine

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25483

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|--|---|--|---|--|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Joseph Lamonte | | | | 2. Date of Death Month August Day 19 Year 1997 | | 3. Time of Death 7:41 AM | | |
| | 4a. Facility Name (If not in institution, give street and number) Mercy Medical Center | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death n/a | | |
| Funeral Director | 5. Social Security Number 219-03-9901 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 77 Yrs. | | 8. Date of Birth (Month, Day, Year) April 16 1920 | | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Md. | | 10b. County n/a | | 10c. City, Town or Location Baltimore | | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 1224 S. Charles Street | | 10f. Zip Code 21230 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No WWII If Yes, Give Year or Dates: 44-46 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Shipping Clerk | | 16b. Kind of Business/Industry Locke Insulator | | 17. Father's Name (First, Middle, Last) Anthony LaMonte | | 18. Mother's Name (First, Middle, Maiden Surname) Josephine Enzenga | |
| 19a. Informant's Name/Relationship (Type, Print) Anna LaMonte (Wife) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1224 S. Charles Street, Baltimore, Md. 21230 | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery | | 20c. Location - City or Town, State Brooklyn Park, Md. | |
| 21. Signature of Funeral Service Licensee Harold A. Taylor | | 22. Name and Address of Facility McCully-Polyniak Funeral Home of South Balto. 130 E. Fort Ave., Baltimore, Md. 21230 | | 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Myocardial Infarction Due to (or as a consequence of): | | Approximate Interval Between Onset and Death 1 day. | | | |
| 23b. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Cerebrovascular Accident | | 23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| 28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Vijay Pethkar MD | | 29c. License number D 0050853 | | 29d. Date signed (Month, Day, Year) August 19, 1997 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Vijay Pethkar 301 St. Paul Place, Baltimore MD 21202. | | 31. Date filed (Month, Day, Year) AUG 22 1997 | | 32. Registrar's Signature Julia Davidson-Randall | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "Natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

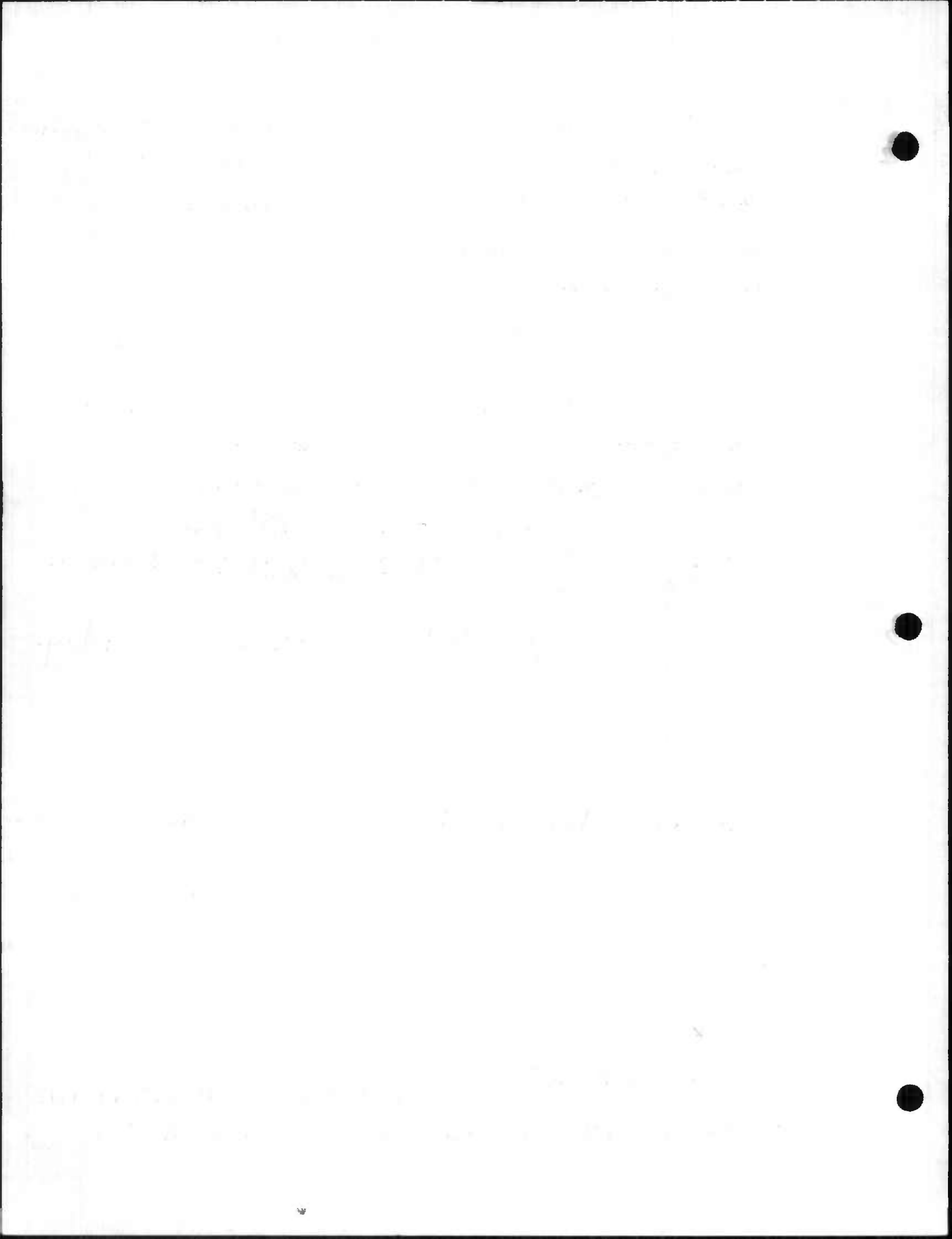
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25484

Certificate of Death

Reg. No.

| | | | | | |
|--|--|--|---|--------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Marie Lerner | | 2. Date of Death Month August Day 16 Year 1997 | | 3. Time of Death 5:20 PM |
| | 4a. Facility Name (If not institution, give street and number) Cherrywood Nursing Center | | 4b. City, Town, or Location of Death Reisterstown | | 4c. County of Death Baltimore |
| Funeral Director | 5. Social Security Number 217-05-5718 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 89 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) Aug 25, 1907 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location Baltimore |
| | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | |
| | 10e. Street and Number 3002-A Fallstaff Manor Ct | | 10f. Zip Code 21209 | | 10g. Citizen of What Country? U.S.A. |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: White | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife | | 16b. Kind of Business/Industry Own Home |
| | 17. Father's Name (First, Middle, Last) John Suess | | 18. Mother's Name (First, Middle, Maiden Surname) Amelia Karch | | |
| | 19a. Informant's Name/Relationship (Type, Print) Mrs Linda R Poretz (Daughter) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28 Halcyon Rd, Newton MA 02159 | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Hebrew | | 20c. Location - City or Town, State 8/19/97 Reisterstown, MD |
| | 21. Signature of Funeral Service Licensee <i>Joel D. Lewis</i> | | 22. Name and Address of Facility Sol Levinson & BROS. 8900 Reisterstown Rd, Pikesville, MD 21208 | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Cerebral Vascular Accident | | | | Approximate Interval Between Onset and Death 6 months |
| | Immediate Cause (Final disease or condition resulting in death) Cerebral Vascular Accident | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Renal Insufficiency | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28. Data of Injury (Month, Day Year) M | | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28b. Time of Injury M | | |
| | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| State Registrar | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>John H. Copeland MD</i> | | 29c. License number D27034 |
| | 29d. Date signed (Month, Day, Year) August 17, 1997 | | | | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Ira H Copeland MD 5310 Old Court Road Randallstown MD 21133 | | | | |
| 31. Date filed (Month, Day, Year) AUG 22 1997 | | 32. Registrar's Signature <i>John Davidson-Randall</i> | | | |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

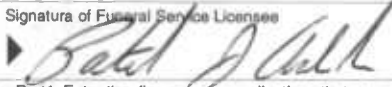
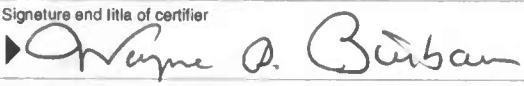

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25485

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|------------------------------------|--|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Duane Leon Lundberg | | | | 2. Date of Death Month Aug Day 18 Year 1997 | | 3. Time of Death 10:54 PM | |
| | 4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center | | | | 4b. City, Town, or Location of Death Annapolis | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 547-36-8023 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 67 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Nov 27 1929 | 9. Birthplace (State or Foreign Country) Iowa |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | 10b. County Anne Arundel | | 10c. City, Town or Location Churchton | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number 5525 Gloucester Street | | | | 10f. Zip Code 20733 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Korea | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home Improvement | | | 16b. Kind of Business/Industry Construction | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Arthur B. Lundberg | | | | 18. Mother's Name (First, Middle, Maiden Surname) Elsie Little | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Lila Mae Steele/Fiancee | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5525 Gloucester St., Churchton, Md 20733 | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory | | 20c. Location - City or Town, State Baltimore, Md | | 20d. Date 08/19/1997 | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave., Annapolis, Md 21401 | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Respiratory Failure Due to (or as a consequence of): b. Upper GI Bleed Due to (or as a consequence of): c. Lung Cancer Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death 3 wks 4 days 1 month |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atrial Fibrillation Pericardial Effusion | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | | |
| | 28f. Location (Street and Number or Rural/Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| | 29b. Signature and title of certifier  | | | | 29c. License number 1038563 | | 29d. Date signed (Month, Day, Year) August 19, 1997 | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wayne D. Bierbaum 134 Owensville Rd West River MD | | | | | | | |
| | 31. Date filed (Month, Day, Year) AUG 22 1997 | | | | 32. Registrar's Signature  | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25486

DDG

WANDA LYLES

Items: 23a part I, 27, 28a-f per MEO G-751 9/2/97 dh

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Wanda Denise Lyles

2. Date of Death

Month

Day

Year

AUGUST 19, 1997

3. Time of Death

12:15P

4a. Facility Name (If not institution, give street and number)

915 NORTH CASTLE STREET

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

5. Social Security Number

219-70-0747

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

38 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

10-13-58

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

Maryland

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2909 Southern Ave.

10f. Zip Code

21214

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Homemaker

17. Father's Name (First, Middle, Last)

JERRA Lyles

18. Mother's Name (First, Middle, Maiden Surname)

TheLma Lyles

19a. Informant's Name/Relationship (Type, Print)

JERRA Lyles

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2909 Southern Ave Balto. Md. 21214

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Natl Mem PK 8/25/97

Data

20c. Location - City or Town, State

Howard Co., Md.

21. Signature of Funeral Service Licensee

Jeff Miller

22. Name and Address of Facility

Jeff Miller P.C. F/H 1639 N. Broadway Balto. Md.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. NARCOTIC INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☒ Could not be determined

28a. Date of Injury (Month, Day, Year)

found: 8/19/97

28b. Time of Injury

found: 12:00

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

unknown

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

found: home

28f. Location (Street and Number or Rural Route Number, City or Town, State) 915 N. Castle Street, Baltimore City, Md.

29a. Certifier (Check only one)

1 ☐ Certifying Physician2 ☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David Fowler

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

AUGUST 20, 1997

30. Name and address of person who completed cause of death (item 23e) (Type, Print)

David Fowler, M.D. 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

AUG 22 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

97 25487

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Marguerite E. Lastner</i> | | | | 2. DATE OF DEATH MONTH <i>8</i> - DAY <i>19</i> - YEAR <i>1997</i> | | 3. TIME OF DEATH <i>12:40 A.M.</i> | |
| 4. SOCIAL SECURITY NUMBER <i>214-16-8636</i> | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 8. AGE (In yrs. last birthday) <i>95</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>July 11, 1902</i> | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>The Wesley Home</i> | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i> | | 9c. COUNTY OF DEATH <i>N/A</i> | | | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE <i>Md</i> | | 10b. COUNTY <i>N/A</i> | | 10c. CITY, TOWN OR LOCATION <i>Baltimore</i> | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <i>2211 West Rogers Avenue</i> | | | | 10f. ZIP CODE <i>21209</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>Unknown</i> College (1-4 or 5+) <i></i> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>Own Home</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>John B. Starklauf</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Sophia</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>The Wesley Home</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2211 West Rogers Avenue Balto, MD 21209</i> | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Moreland Memorial</i> | | 20c. DATE <i>8/21</i> | | 20d. LOCATION — City or Town, State <i>Parkville, MD</i> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael Carpenter</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Burgee-Henss Funeral Home 3631 Falls Rd. Balto, MD 21211</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Atherosclerotic Vascular Disease</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>b. Advanced Age.</i> DUE TO (OR AS A CONSEQUENCE OF): <i>c.</i> DUE TO (OR AS A CONSEQUENCE OF): <i>d.</i> | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>R. Libertus</i> | | | | 29c. LICENSE NUMBER <i>D11464</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>8/20/97</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>3508 Bank St Balto, Md 21224 Robert Libertus, MD.</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>AUG 22 1997</i> | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25488

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|---|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) BERNARD H. LAZARUS | | | | 2. Date of Death Month Day Year August 11, 1997 | | 3. Time of Death 3:00 PM | |
| | 4a. Facility Name (If not institution, give street and number) 1916 Lebanon Street | | | | 4b. City, Town, or Location of Death Hyattsville | | 4c. County of Death Prince George's | |
| Funeral Director | 5. Social Security Number 130-20-4079 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 69 Yrs. | | 8. Date of Birth (Month, Day, Year) Dec. 19, 1927 | |
| | 9. Birthplace (State or Foreign Country) New York | | 10a. State Maryland | | 10b. County Prince Georges | | 10c. City, Town or Location Hyattsville | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street end Number 1916 Lebanon Street | | 10f. Zip Code 20783 | | 10g. Citizen of What Country? U. S. A. | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: to 1966 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years College (1-4or 5+) College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Photographer | | 16b. Kind of Business/Industry Photography | | | | |
| 17. Father's Name (First, Middle, Last) Albert Lazarus | | | | 18. Mother's Name (First, Middle, Maiden Surname) Myra Lasner | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mona Lazarus | | | | 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 1916 Lebanon Street, Hyattsville, Md. 20783 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cemetery | | 20c. Location - City or Town, State Arlington, Virginia | | 20d. Date 8/15/97 | | |
| 21. Signature of Funeral Service Licensee Donald C. Stettin | | | | 22. Name and Address of Facility STEIN HEBREW MEMORIAL FUNERAL HOME, INC. 232 CARROLL STREET, N.W., WASHINGTON, D.C. 20012 | | | | |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Cryptogenic cirrhosis Due to (or as a consequence of): f. Due to (or as a consequence of): g. Due to (or as a consequence of): h. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atherosclerotic Coronary Artery Disease | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street end Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier John D. Horwath | | | | 29c. License number MD 053834-L | | 29d. Date signed (Month, Day, Year) AUGUST 12 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) JOHN DAVID HORWATH MD WALTER REED ARMY MEDICAL CENTER, WASH. DC. | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 22 1997 | | | | 32. Registrar's Signature John D. Horwath | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 25489

Reg. No.

| | | | | | | | | |
|---|--|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Marie Rose Miller | | | | 2. Date of Death Month Day Year Aug. 19, 1997 | | 3. Time of Death 8:40pm | |
| | 4a. Facility Name (If not institution, give street and number) Corsica Hills Nursing Home | | | | 4b. City, Town, or Location of Death Centreville | | 4c. County of Death Queen Anne | |
| Funeral Director | 5. Social Security Number 216-07-5843 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 88 Yrs. | | 8. Date of Birth (Month, Day, Year) Aug. 20, 1908 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 10e. Street and Number 1834 Ramsey Street | | | | 10f. Zip Code 21230 | | 10g. Citizen of What Country? United States | |
| | 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 Collage (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) coat pad maker | | 16b. Kind of Business/Industry garment | | | |
| | 17. Father's Name (First, Middle, Last) George M. Miller | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Agnes Ziegler | | | |
| Physician /Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Lorraine White, niece | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 146 Stevensville, Maryland 21666 | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory | | 20c. Date 8/20 | | 20d. Location - City or Town, State Catonsville, Maryland | |
| | 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Road | | 22b. City, State, Zip Code Arbutus 21227 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Septic Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia Decubitus ulcer, sacral | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier  | | 29c. License number D50295 | | 29d. Date signed (Month, Day, Year) 8/21/97 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERIC HERMAN 2108 DIDONATO DRIVE CHESTER, MD 21619 | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 22 1997 | | 32. Registrar's Signature  | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 25490

Item:18 per FH G-750 8/22/97 dh

Reg. No.

| | | | | | | | | | |
|--|---|---|--|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) John Murray Miller | | | | 2. Date of Death Month August Day 17 Year 1997 | | 3. Time of Death 6:10 pm | | |
| | 4a. Facility Name (If not Institution, give street and number) Greater Baltimore Medical Center | | | | 4b. City, Town, or Location of Death Towson | | 4c. County of Death Baltimore | | |
| Funeral Director | 5. Social Security Number 219 28 3875 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 64 Yrs. | 8. Date of Birth (Month, Day, Year) March 11, 1933 | | 9. Birthplace (State or Foreign Country) Balto. City | | |
| | 10a. State MARYLAND | | 10b. County BALTIMORE | | 10c. City, Town or Location SPARKS | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 142 English Run Circle | | | | 10f. Zip Code 21152 | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collega (1-4or 5+) 1 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Management | | 16b. Kind of Business/Industry Medical Supplies | | | |
| 17. Father's Name (First, Middle, Last) Lewis Herbert Miller | | | | 18. Mother's Name (First, Middle, Maiden Sumama) Cecilia Mildred Cecelia Hoeckel | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Constance A. Miller | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 142 English Run Circle, Sparks, MD 21152 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St. James Episcopal Cem. | | Data 21 Aug 1997 | | 20c. Location - City or Town, State Monkton, MD | | | |
| 21. Signature of Funeral Service Licensee Victor Lengrand, Jr. | | | | 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Massive Pulmonary Embolism Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | Approximate interval Between Onset and Death 5 minutes | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| operation 8/13/97 segmental colectomy for bowel cancer | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA | | Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 26. Place of Death (Check only one) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier [Signature] | | 29c. License number D00875 | | 29d. Date signed (Month, Day, Year) 8/18/97 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rudiger Breitenacker M.D. Greater Baltimore Medical Center | | | | | | | | 6701 N. Charles St. Baltimore, MD 21204 | |
| 31. Date filed (Month, Day, Year) AUG 22 1997 | | | | 32. Registrar's Signature [Signature] | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

John Murray Miller
Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28c-f show any injury or other traumatic event, the Medical Examiner must be notified and all

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 25491**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Evern MIHALKO

2. Date of Death Day Month Year 17, 1997 August 3. Time of Death 4:20 PM

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

219-12-5872

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year Months Days

If Under 24 Hrs. Hours Min.

8. Date of Birth (Month, Day, Year)

1-19-15

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Rosedale

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

8505 Coco Rd.

10f. Zip Code

21237

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
 If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 12

College (1-4 or 5+) 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Security Guard

16b. Kind of Business/Industry

Martin Marietta

17. Father's Name (First, Middle, Last)

John Mihalko

18. Mother's Name (First, Middle, Maiden Surname)

Anna (unk.)

19a. Informant's Name/Relationship (Type, Print)

Anna L. Tilley / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8505 Coco Rd. Rosedale, MD 21237

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith

Date

8-20-97

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Denis S. Kelly

22. Name and Address of Facility

Cvach/Rosedale Funeral Home
 1211 Chesaco Ave. Rosedale, MD 21237

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Colon Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 Months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dawn Warner DO

29c. License number

RD # 02346

29d. Date signed (Month, Day, Year)

8/17/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dawn Warner DO. 9000 Franklin Square Dr. Balto, Md. 21237

31. Date filed (Month, Day, Year)

AUG 22 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25492

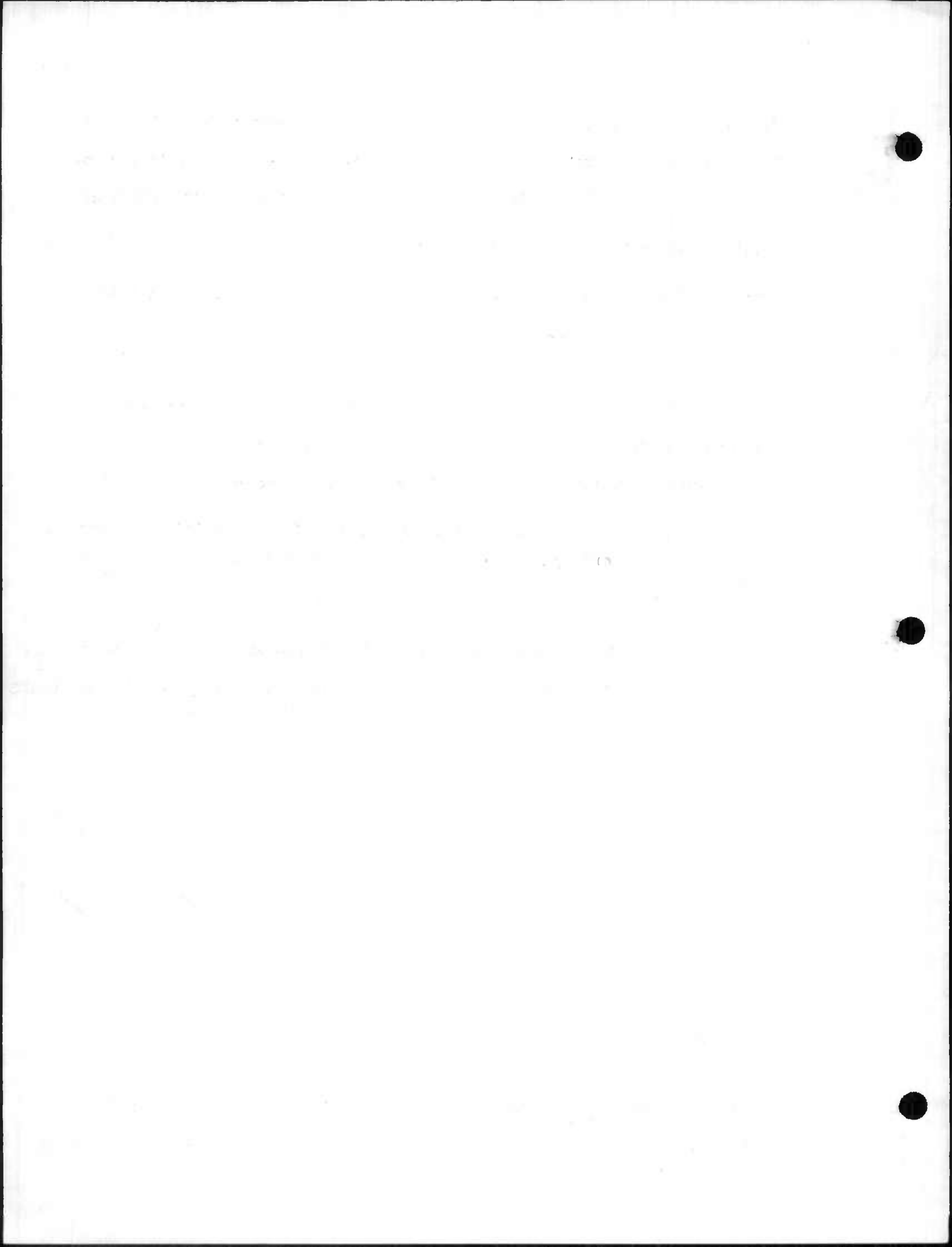
Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Minna Vertalee McCusker | | | | 2. Date of Death Month August 17, 1997 Year | | 3. Time of Death 8:15 AM | |
| | 4a. Facility Name (If not institution, give street and number) Charlestown Nursing Center | | | | 4b. City, Town, or Location of Death Catonsville | | 4c. County of Death Baltimore Co. | |
| Funeral Director | 5. Social Security Number 213-74-4392 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 94 Yrs. | | 8. Date of Birth (Month, Day, Year) Aug. 23, 1902 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Baltimore Co. | | 10c. City, Town or Location Catonsville | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 10e. Street and Number 709 Maiden Choice Lane Apt. S-421 | | 10f. Zip Code 21228 | |
| | 10g. Citizen of What Country? United States | | | | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home Maker | | 16b. Kind of Business/Industry Own Home | |
| | 17. Father's Name (First, Middle, Last) Joseph George Nieman | | | | 18. Mother's Name (First, Middle, Maiden Surname) Carrie Lang | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Mrs. Vertalee M. Pillsbury (Dau.) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 317 Chapelwood Lane Lutherville, Md. 21093 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery | | 20c. Location - City or Town, State Baltimore, Maryland | |
| | 21. Signature of Funeral Service Licensee Jeffrey L. Gair | | | | 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Congestive heart failure Due to (or as a consequence of): b. Atherosclerotic coronary artery disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 10 days | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) 28b. Time of injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| | 29b. Signature and title of certifier Myra M. Carpenter MD | | | | 29c. License number D30989 | | 29d. Date signed (Month, Day, Year) 08/18/97 | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Myra M. Carpenter MD 711 Maiden Choice Ln Catonsville MD | | | | | | | |
| | 31. Date (Month, Day, Year) AUG 22 1997 Registrar's Signature John Davidson-Randall | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John Richard Matthews

2. Date of Death

Month
AUGUSTDay
15Year
1997

3. Time of Death

1:31 A

Funeral
Director

4a. Facility Name (If not institution, give street and number)

JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

246-42-0772

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

64 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 18, 1932

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Md.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

908 N. Milton Avenue

10f. Zip Code

21205

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 3-24-64 to 2-20-69

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th grade

College (1-4 or 5+)

College

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Acid Blender

16b. Kind of Business/Industry

Md. Chemical Company

17. Father's Name (First, Middle, Last)

Dewitt Matthews Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Grace Dobson

19a. Informant's Name/Relationship (Type, Print)

Maggie Martin (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4110 Carnation Drive, Winston-Salem, N.C. 27105

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

8-21-97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Sharon D. Boykins

22. Name and Address of Facility

Joseph H. Brown Jr. Funeral Home, P.A.
2140 N. Fulton Avenue, Baltimore, Maryland 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

INSPECTION

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☒ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Marilyn A. Koron

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

AUGUST 15, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Marilyn A. Koron

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

AUG 22 1997

32. Registrar's Signature

Julia Davidson-Rodriguez

State

Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25494

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>Brian Andre Harris Overton</i> | | | | 2. Date of Death Month <i>August</i> Day <i>16</i> Year <i>1997</i> | | 3. Time of Death <i>12:40 P.M.</i> | |
| | 4a. Facility Name (If not institution, give street and number) <i>The Johns Hopkins Hospital</i> | | | | 4b. City, Town, or Location of Death <i>Baltimore</i> | | 4c. County of Death <i>N/A</i> | |
| Funeral Director | 5. Social Security Number <i>N/A</i> | | 6. Sex <i>1</i> M <i>2</i> F | | 7. Age (In yrs. last birthday) <i>N/A</i> Yrs. | | 8. Date of Birth (Month, Day, Year) <i>August 13, 1997</i> | |
| | 9. Birthplace (State or Foreign Country) <i>Maryland</i> | | 10a. State <i>md</i> | | 10b. County <i>Baltimore</i> | | 10c. City, Town or Location <i>Rosedale</i> | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <i>1</i> Yes <i>2</i> No | | 10e. Street and Number <i>2310 Crossett Road</i> | | 10f. Zip Code <i>21237</i> | | 10g. Citizen of What Country? <i>USA</i> | |
| | 11. Marital Status <i>1</i> X Navar Married <i>2</i> Married <i>3</i> Widowed <i>4</i> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? <i>1</i> Yes <i>2</i> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <i>1</i> Yes <i>2</i> X No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <i>Black</i> | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>0</i> College (1-4 or 5+) <i>0</i> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>None</i> | | 16b. Kind of Business/Industry <i>Infant</i> | | | |
| | 17. Father's Name (First, Middle, Last) <i>Andre Overton</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <i>Sabriya Rose Harris</i> | | | |
| | 19a. Informant's Name/Relationship (Type, Print) <i>Sabriya Harris / Mother</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2310 Crossett Road, Rosedale, Md 21237</i> | | | |
| | 20a. Method of Disposition <i>1</i> X Burial <i>2</i> Cramation <i>3</i> Removal from State <i>4</i> Donation <i>5</i> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Oak Lawn Cemetery</i> | | 20c. Location - City or Town, State <i>8-21-97 Baltimore, MD</i> | | | |
| | 21. Signature of Funeral Service Licensee <i>Dennis S. Kelly</i> | | | | 22. Name and Address of Facility <i>Cvach/Rosedale Funeral Home 1211 Chesaco Ave. Rosedale, MD 21237</i> | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <i>SEPTIS</i> Due to (or as a consequence of): a. <i>SEPTIS</i> b. <i></i> c. <i></i> d. <i></i> Approximate Interval Between Onset and Death <i>1 day</i> | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. <i>Pulmonary hypertension</i> | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <i>1</i> Yes <i>2</i> X No <i>3</i> Probably <i>4</i> Unknown | | | | | | | |
| 24a. Was an autopsy performed? <i>1</i> X Yes <i>2</i> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of causa of death? <i>1</i> Yes <i>2</i> X No | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <i>1</i> Yes <i>2</i> X No | | 26. Place of Death (Check only one) Hospital: <i>1</i> Inpatient <i>2</i> ER/Outpatient <i>3</i> DOA Other: <i>4</i> Nursing Home <i>5</i> Residence <i>6</i> Other (Specify) | | | | | |
| | 27. Manner of Death <i>1</i> Natural <i>5</i> Pending investigation <i>2</i> X Accident <i>6</i> Could not be determined <i>3</i> Suicide <i>4</i> Homicide | | 28a. Date of Injury (Month, Day Year) <i></i> | | 28b. Time of Injury <i>M</i> | | 28c. Injury at Work? <i>1</i> Yes <i>2</i> X No | |
| | | | 28d. Describe how injury occurred <i></i> | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) <i></i> | | | |
| | 29a. Certifier (Check only one) <i>1</i> X Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner as stated. <i>2</i> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier <i>Dave G. N. [Signature]</i> | | | | 29c. License number <i>D30312</i> | | 29d. Date signed (Month, Day, Year) <i>August 18, 1997</i> | |
| State Registrar | 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <i>David G. Nichols 600 N. Wolfe Street, Baltimore, Md 21287</i> | | | | | | | |
| | 31. Date filed (Month, Day, Year) <i>AUG 22 1997</i> | | | | 32. Registrar's Signature <i>Julia Davidson-Randall</i> | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 25495

Reg. No.

| | | | | | | | | | |
|--|--|---|---|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Marie Anna Olszewski | | | | 2. Date of Death Month 8 Day 19 Year 1997 | | 3. Time of Death 11:15AM | | |
| | 4a. Facility Name (If not institution, give street and number) Franklin Woods Rehabilitaion Center | | | | 4b. City, Town, or Location of Death White Marsh | | 4c. County of Death Baltimore | | |
| Funeral Director | 5. Social Security Number 213-20-9338 | | 8. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 80 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Aug. 11 17 | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent 10a. State Maryland 10b. County Baltimore 10c. City, Town or Location Dundalk 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number 628 47'th Sreet Apt. C. | | 10f. Zip Code 21224 | | |
| To Be Completed by Funeral Director | 10g. Citizen of What Country? U.S.A. | | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | |
| | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4or 5+) NA | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Inspector of Assembly line | | 16b. Kind of Business/Industry National Can Corp. | | |
| | 17. Father's Name (First, Middle, Last) Edward Schmidt | | | | 18. Mother's Name (First, Middle, Maiden Sumame) Marie Sirnek | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Audrey Swieczkowski-Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 655 47'th St. Dundalk, Maryland 21224 | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Redeemer | | 20c. Location - City or Town, State Baltimore, Maryland | | 20d. Date August 22 | | |
| | 21. Signature of Funeral Service Licensee <i>Mark A. Rejnacki</i> | | | | 22. Name and Address of Facility W. Dabrowski/Chojnacki F.H.P.A. 1005 Dundalk Ave. Baltimore, Maryland 21224 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hepatoma Due to (or as a consequence of): b. Malnutrition Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | Approximate Interval Between Onset and Death 1 year 6 months | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of causa of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>John A. Henderson</i> | | 29c. License number D45475 | | 29d. Date signed (Month, Day, Year) 8/20/97 | | 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) Mohammad Rahvana M.D. 17 Fontana Lane Rosedale, Md. 21233 | |
| 31. Date filed (Month, Day, Year) AUG 22 1997 | | 32. Registrar's Signature <i>John A. Henderson</i> | | | | | | | |

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

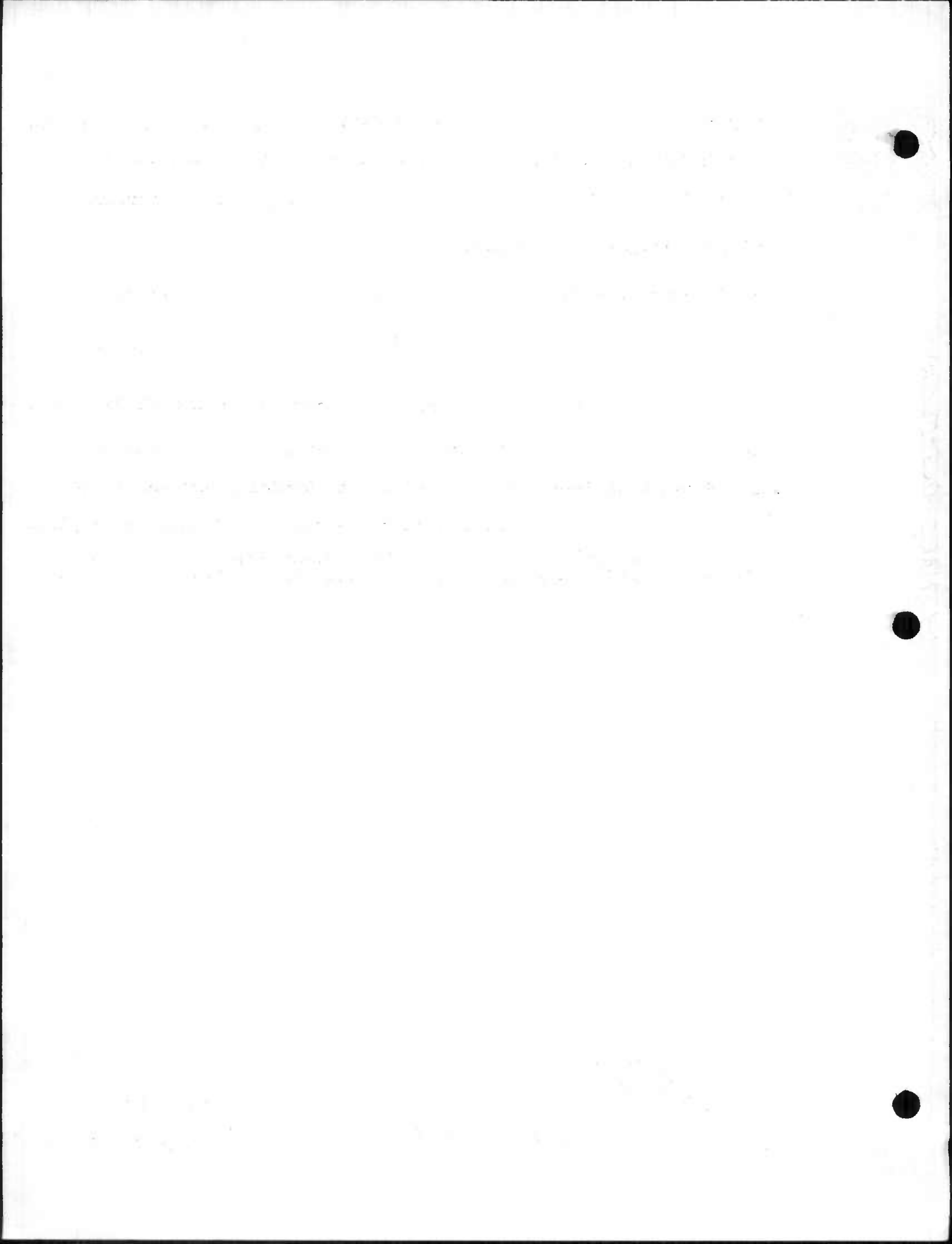
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25496

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|---|--|--|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MARGARET C. PUMPHREY | | | | 2. Date of Death Month Aug Day 19 Year 1997 | | 3. Time of Death 4:12 PM | |
| | 4a. Facility Name (If not institution, give street and number) HOWARD COUNTY GENERAL HOSPITAL | | | | 4b. City, Town, or Location of Death COLUMBIA | | 4c. County of Death HOWARD | |
| Funeral Director | 5. Social Security Number 032-20-3676 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 76 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) JAN. 16, 1921 | 9. Birthplace (State or Foreign Country) MARYLAND |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MARYLAND | | 10b. County HOWARD | | 10c. City, Town or Location ELLCOTT CITY | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 9009 CRESTLEIGH ROAD | | | | 10f. Zip Code 21042 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collegia (1-4or 5+) 2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CHOIR DIRECTOR | | 16b. Kind of Business/Industry CHURCH CHOIR | | |
| 17. Father's Name (First, Middle, Last) MARION WALKER COE | | | | 18. Mother's Name (First, Middle, Maiden Surname) ANNA HAMMOND | | | | |
| 19a. Informant's Name/Relationship (Type, Print) ANN COE PUMPHREY (DAUGHTER) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9009 CRESTLEIGH ROAD, ELLCOTT CITY, MD. 21042 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) CHESAPEAKE CREMATORY, INC. 8/22/97 BELTSVILLE, MD. | | 20c. Location - City or Town, State | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. BRAIN STEM STROKE Due to (or as a consequence of): b. Hypertension Due to (or as a consequence of): c. Diabetes Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death minutes. years years |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. obesity | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier | | 29c. License number D31473 | | 29d. Date signed (Month, Day, Year) Aug 20, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PATRICE A. TOYE, MD 4565 Hemlock Cone Way Ellicott City MD 21042 | | | | | | | | |
| 31. Date filed (Month, Day, Year) AUG 22 1997 | | 32. Registrar's Signature | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25497

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Doris Parks

2. Date of Death

Month August Day 20, Year 1997

3. Time of Death

12:20 AM

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

578-22-6945

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) Dec 19 1924

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Deale

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

623 Windsor Place

10f. Zip Code

20751

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Mail Carrier

16b. Kind of Business/Industry

Postal Service

17. Father's Name (First, Middle, Last)

Joseph E. Mullen

18. Mother's Name (First, Middle, Maiden Summa)

Luellin Kinslow

19e. Informant's Name/Relationship (Type, Print)

SON

Alfred H. Parks II, 102 Merowe Ct., Cary, N.C. 27513

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Cedar Hill Cemetery

Date

8/23

1997

20c. Location - City or Town, State

Suitland, Md

21. Signature of Funeral Service Licensee

Bartek J. Arnold

22. Name and Address of Facility

Hardesty Funeral Home, P.A. 12 Ridgely
Ave., Annapolis Md 2140123e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. congestive heart failure

Approximate
Interval Between
Onset and Death

months

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD

? Carcinoma of lung

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Suresh A. Patel

29c. License number

D46478

29d. Date signed (Month, Day, Year)

8-21-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Suresh A. Patel, M.D. 7501 Surratts Rd # 307. Clinton, MD 20735

31. Date filed (Month, Day, Year)

AUG 22 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

97 25498

Reg. No.

DHHM 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25499

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|---|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ISADORE G. ROSE | | | | 2. Date of Death Month Day Year AUGUST 19, 1997 | | 3. Time of Death 6:55 AM | |
| | 4a. Facility Name (If not institution, give street and number) 2458 SHADY WOOD CIRCLE | | | | 4b. City, Town, or Location of Death CROFTON | | 4c. County of Death ANNE ARUNDEL | |
| Funeral Director | 5. Social Security Number 056-14-8367 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 88 Yrs. | | 8. Date of Birth (Month, Day, Year) AUG 6 1909 | |
| | 9. Birthplace (State or Foreign Country) NEW YORK | | 10a. State NY | | 10b. County SCHENECTADY | | 10c. City, Town or Location SCHENECTADY | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 2137 NISKAYUNA DRIVE | | 10f. Zip Code 12309 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SALES REP | | 16b. Kind of Business/Industry BAKING & TOBACCO INDUSTRY | | 17. Father's Name (First, Middle, Last) PHILLIP ROSE | |
| | 18. Mother's Name (First, Middle, Maiden Surname) REBECCA GRAFF | | 19a. Informant's Name/Relationship (Type, Print) PHILIP ROSE, SON | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2458 SHADY WOOD CIRCLE, CROFTON, MD 21114 | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place) WOODLAWN CEMETERY | | 20c. Location - City or Town, State 8-22 SYRACUSE, NY | | 21. Signature of Funeral Service Licensee <i>Phillip Stank</i> | | 22. Name and Address of Facility STERLING ASHTON FUNERAL HOME, INC. 736 EDMONDSON AVE. CATONSVILLE, MD 21228 | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. end stage congestive heart failure Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | |
| | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| To Be Completed by Physician/Medical Examiner | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier <i>Daryl Milles M.D.</i> | | 29c. License number 026621 | |
| | 29d. Date signed (Month, Day, Year) August 19, 1997 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gary Milles 3460 Ellicott Center Drive, Ellicott City, Md. 21044 | | 31. Date filed (Month, Day, Year) AUG 22 1997 | | 32. Registrar's Signature <i>Julia Davidson-Randall</i> | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit certificate filed in by the funeral director.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 25500

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedant's Name (First, Middle, Last) GEORGE W. ROLF, SR. | | | | 2. Date of Death Month August Day 14 Year 1997 | | 3. Time of Death 1859 | |
| | 4a. Facility Name (If not institution, give street and number) Sinai Hospital | | | | 4b. City, Town, or Location of Death Baltimore City | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 216-03-8451 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 78 Yrs. | | 8. Date of Birth (Month, Day, Year) March 1, 1919 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 10e. Street and Number 124 West Clement Street | | 10f. Zip Code 21230 | |
| | 10g. Citizen of What Country? United States | | | | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No WWII If Yes, Give Year or Dates: 1945 | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 Collage (1-4 or 5+) 0 | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Trimmer | | | | 16b. Kind of Business/Industry General Motors | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) George J. Rolf | | | | 18. Mother's Name (First, Middle, Maiden Sumama) Mary C. Wheltle | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Anna D. Parker / daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1947 Sponson Street, Baltimore MD 21230 | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Cross Cemetery | | 20c. Location - City or Town, State Brooklyn Park MD | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility McCully-Polyniak Funeral Home of South Baltimore 130 East Fort Avenue, Baltimore MD 21230 | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Myocardial infarction Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | Approximate Interval Between Onset and Death hours | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ventricular tachycardia | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 28d. Describe how injury occurred | | | |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier  | | | |
| To Be Completed by Physician/Medical Examiner | 29c. License number D37573 | | | | 29d. Date signed (Month, Day, Year) August 15, 1997 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeffrey Zibell, M.D. 7220 Park Heights Avenue Baltimore MD 21208 | | | | 31. Date filed (Month, Day, Year) AUG 22 1997 | | | |
| To Be Completed by Physician/Medical Examiner | 32. Registrar's Signature  | | | | 33. State Registrar AUG 22 1997 | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

6x1

